FAMILY AND MEDICAL LEAVE (FMLA)

Employee Return to Work Certification

FMLA@billingsmt.gov

EMPLOYEE: FOR RETURN TO WORK FROM OWN MEDICAL LEAVE PLEASE COMPLETE THIS PORTION AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER TO CERTIFY YOU ARE ABLE TO RETURN TO WORK.
Employee's Name:
Employee's Cell #:
Employee's Personal Email:
Employee's Department:
Employee's Job Title:
Supervisor Name:

HEALTH CARE PROVIDER: PLEASE COMPLETE AND RETURN TO EMPLOYEE	
Is the employee able to perform all the functions of his or her job, per their job description? ☐ No ☐ Yes ☐ Yes, with restrictions.	
Please list any restrictions or functional limitations which the department should consider:	
Are the above restrictions: ☐ Permanent ☐ Temporary, until (date):	
Comments:	
Employee is released to return to work effective (date):	
Printed Name of Health Care Provider facility:	
Printed Physician Name:	
Signature of Health Care Provider: _______________________________	Date: ______________

Please email (FMLA@billingsmt.gov) or call FMLA Coordinator at (406)657-8265 if you have any questions.