MERCER UNIVERSITY

MERC MERCER ENGINEERING RESEARCH CENTER
An Operating Unit Of Mercer University

RETURN TO WORK AUTHORIZATION

Family and Medical Leave (FMLA)

SECTION I – To be completed by Employee

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)

JOB TITLE

DEPARTMENT

SECTION II – To be completed by Employee's Healthcare Provider

PLEASE COMPLETE THE FOLLOWING AND RETURN THE FORM TO THE EMPLOYEE OR TO THE HUMAN RESOURCES OFFICE BY EMAIL TO graham_n@mercer.edu OR BY FAX TO (478) 301-2790 PRIOR TO THE RETURN TO WORK DATE.

Important: Please limit your answers below to the serious health condition for which the employee has most recently been on leave.

A. Employee named in Section 1 can return to work on _____. (*indicate date)*

B. Is the employee able to perform the essential functions of their job upon their return to work?

☐ No ☐ Yes, with no restrictions. ☐ Yes, with the restriction(s) listed in section C.

C. If the employee is restricted in their ability to perform the essential functions of their job, please describe the needed restrictions. If light duty, please explain.

D. The above restrictions are:

☐ Permanent ☐ Temporary until _____. *(indicate date)*

E. Additional Comments (if needed):

SECTION III – Healthcare Provider's Contact Information

HEALTHCARE PROVIDER'S NAME

ADDRESS

PHONE NUMBER

Signature of Healthcare Provider **Date**

Revised 1/2017