CITY OF CLARKSVILLE

FAMILY AND MEDICAL LEAVE
RETURN TO WORK MEDICAL CERTIFICATION FORM

(Type or Print)

PART I EMPLOYEE INFORMATION

❶ Name: Social Security Number:	❷ Title: Department:
❸ Date Leave Commenced:	❹ Date of Return to Work:

❺ Employee's signature: _____ Date: _____

PART II TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

❻ *I certify that on _____ (date), I examined _____ (name of employee), and on the basis of my examination, this employee is ready to return to work and is able to perform the functions of his/her position.*

Signed: _____ Date: _____

❼ Health Care Provider's Name, Address, and Telephone Number:

PART III TO BE COMPLETED BY EMPLOYER

Employer Remarks:

This form should be delivered or mailed to:

City of Clarksville., ATTN: Human Resources

1 Public Square, Suite 200

Clarksville, TN 37040

MS 413
L11.99