KING WILLIAM COUNTY PUBLIC SCHOOLS FMLA
RETURN TO WORK AUTHORIZATION FORM

CONFIDENTIAL

Name of Physician/Healthcare Provider: _____

Contact Number for Physician/Healthcare Provider: _____

Name of Employee: _____

Instructions: To be completed in full by physician/healthcare provider.

1. Medical Diagnosis: _____

_____

2. Based on your examination(s) of the above named employee, are there any known problems of a general nature, including any medications prescribed for the diagnosis listed, that would interfere with the employee returning to work?

☐ **No**

☐ **Yes - please explain**: _____

_____

3. The patient may return to work:

☐ **Without** restrictions on _____(date).

☐ **With** restrictions on _____(date). **Restrictions are as follows**:

_____

_____

4. When will the employee no longer be subject to the above restrictions? _____(Date)

_____ _____

Signature of Physician/Healthcare Provider Date

7/2016