UNIVERSITY of LOUISIANA LAFAYETTE

RETURN-TO-WORK CERTIFICATION

For Family Medical Leave

SECTION I – To be completed by THE EMPLOYER		
EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)		
EMPLOYEE'S DEPARTMENT	LEAVE START DATE	LEAVE END DATE
DEPARTMENT CONTACT **Malika Oubre, Senior Benefits/ADA Coordinator**		
DEPARTMENT CONTACT'S MAILING ADDRESS **PO Box 40196, Lafayette, LA 70504**		
PHONE **(337) 482-1014**	FAX **(337) 482-1452**	E-MAIL **malika.oubre@louisiana.edu**

SECTION II – To be completed by HEALTH CARE PROVIDER	
NAME OF HEALTH CARE PROVIDER	
ADDRESS	PLACE ADDRESS STAMP HERE:

PLEASE COMPLETE THE FOLLOWING AND RETURN THE FORM TO THE EMPLOYEE OR TO THE DEPARMENT CONTACT LISTED ABOVE PRIOR TO THE RETURN-TO-WORK DATE

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

1. Is the employee now able to perform those essential functions of his or her job that she could not previously perform because of the serious health condition for which the employee has been on leave?

   ☐ No.

   ☐ Yes.

   ☐ Yes, with restrictions

2. Employee released to return to work effective _____ *[indicate date]*

3. If the Employee is released to work but is restricted in their ability to perform the essential functions of their job as a result of the serious health condition for which the employee has been on leave, please describe those restrictions **(if not applicable, please enter NA):**

4. The restrictions are (if applicable):

   ☐ Permanent

   ☐ Temporary, until _____ [*indicate date]*

SIGNATURE and D	
SIGNATURE OF HEALTH CARE PROVIDER	DATE