CITY OF LINCOLN NEBRASKA

RETURN TO WORK CERTIFICATION
For Medical Leave or FMLA

Person ID#: _____

DOC: RTW

SECTION I - EMPLOYEE

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

EMPLOYEE'S DEPARTMENT

EMPLOYER'S CONTACT

EMAIL: Risk@lincoln.ne.gov	FAX: 402-441-6800	PHONE: 402-441-7597 option 5

SECTION II – HEALTH CARE PROVIDER

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

NAME OF HEALTH CARE PROVIDER	PLACE ADDRESS STAMP HERE:
ADDRESS	

1. Is the employee now able to perform those essential functions of their job that they could not previously perform because of a serious health condition you recently treated them for (select one)?

☐ No

☐ Yes, WITH restrictions that are: ☐ Permanent

☐ Temporary, until: _____ *[indicate date]*

Please describe restrictions here:

☐ Yes, may return to full duty WITHOUT restrictions

2. Employees next visit (if applicable) is scheduled for*[indicate date]*:

3. Employee released to return to work effective *[indicate date]*:

SIGNATURE OF HEALTH CARE PROVIDER	DATE