LINCOLN

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