UNIVERSITY CORPORATION AT MONTEREY BAY
100 Campus Center, Seaside, California 93955-8001

Family and Medical Leave
Return to Work Certification

Employee:

Employee's Department:

Department Contact:

Telephone Number:

Health Care Provider Section

Please complete the following and return to the department prior to the return to work date.

Please review the attached job description. Is the employee able to perform all the functions of his or her job?___Yes ___No
_____ Yes, with restrictions or accommodations.

Please list any restrictions or describe accommodations which the department should consider:

Are the restrictions:____Permanent ____Temporary, until (date): _____

Comments:

Employee is released to return to work effective (date):

Name of Health Care Provider:

Specialty:

Address:

Signature of Health Care Provider_____Date_____

Place address stamp here.

RETN: 3 YEARS

Copy to University Corporation HR