HUMAN RESOURCES
JACKSONVILLE STATE UNIVERSITY

Medical Leave
Return to Work Certification

EMPLOYEE: PLEASE COMPLETE THE TOP PORTION AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER

Employee Name:

Employee's Department:

Department Contact:

Telephone Number:

HEALTH CARE PROVIDER: PLEASE COMPLETE AND RETURN DIRECTLY TO DEPARTMENT PRIOR TO RETURN TO WORK DATE

Please review the attached job description. Is the employee able to perform all of the functions of his or her job?
☐ Yes ☐ No ☐ Yes, with restrictions or accommodations

When did the serious health condition begin?

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

Are the restrictions: ☐ Permanent ☐ Temporary until:
If so, please describe the recommended schedule.

Comments:

Employee is released to return to work, effective: _____

Name of Health Care Provider:

Specialty:

Address:

_____ _____
Signature of Health Care Provider Date

Instruction upon completion

Please return signed form to:
hrconfidential@jsu.edu or Fax to: 256-782-5579;
or mail to: JSU Human Resources
700 Pelham Road North
Bibb Graves Hall, Suite 326A
Jacksonville, AL 36265-1602

Retain for 3 Years