

Intent To Return To Work and Medical Release Form

TO: _____
(Supervisor's Name)

FROM: _____ Employee ID Number
(Employee's Name)

I affirm my intent to return to my normal duties full-time part-time on _____.

I am requesting modified light duty.

Employee's Signature

Date

Medical Release

This section must be completed by your doctor when returning to work after delivering a child, or due to your own serious health condition.

_____ The above named employee has been under my treatment for _____
and is release to return to their normal work duties Full-time Part-time on
_____ (date) If part-time duration of status _____ (date)

_____ The employee is released to work their modified duty light duty
until _____ (date)

For modified or light duty, describe the employee's limitations and restrictions:

Print name of Health Care Provider

Signature of Health Care Provider

Date

Type of Practice

License Number Issued by
Florida Board of Examiners

Health Care Provider's Address

Telephone Number

Please submit this form to your department two weeks prior to the end of your leave of absence. Your department is responsible for submitting this form to Human Resources along with a Personnel Action Form to return you from leave.