FAMILY AND MEDICAL LEAVE
RETURN TO WORK CERTIFICATION

CLASSIFIED PERSONNEL DEPARTMENT

EMPLOYEE

EMPLOYEE NAME:	LAST	FIRST	MIDDLE INITIAL
JOB CLASSIFICATION TITLE:			
DEPARTMENT/SCHOOL:			
IMMEDIATE SUPERVISOR:			
CONTACT INFORMATION:	PHONE	EMAIL	

HEALTH CARE PROVIDER

PLEASE COMPLETE SECTION BELOW TO CERTIFY A RETURN TO WORK DATE FOR EMPLOYEE PRIOR TO RETURN DATE.

DATE EMPLOYEE IS RELEASED TO RETURN TO WORK:	

PLEASE REVIEW THE ATTACHED JOB DESCRIPTION. IS THE INDIVIDUAL IN YOUR CARE (I.E. EMPLOYEE) ABLE TO PERFORM ALL THE FUNCTIONS OF THE JOB?

☐ YES: NO RESTRICTIONS ☐ YES: WITH RESTRICTIONS ☐ NO

RESTRICTION TYPE:	☐ PERMANENT	☐ TEMPORARY (SPECIFY APPROXIMATE DATE) _____ DATE

PLEASE LIST ANY RESTRICTIONS OR DESCRIBE ACCOMMODATIONS WHICH THE DEPARTMENT SHOULD CONSIDER:

NAME OF HEALTH CARE PROVIDER:		
SPECIALTY:		
PROVIDER ADDRESS:		
	STREET	
	CITY, STATE	ZIP CODE

I CERTIFY THE INFORMATION PROVIDED ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE

SIGNATURE OF HEALTH CARE PROVIDER DATE

PLEASE SEND COMPLETED FORM TO:

MAIL: CVUSD CLASSIFIED PERSONNEL
1400 EAST JANSS ROAD
THOUSAND OAKS, CA 91362
FAX: 805-494-3741