



Medical Clearance to Return to Work

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This form is to be completed by employees returning to work after a period of consecutive leave related to their own health condition.

Section A: For Completion by Employee

Employee Name:	
Employee ID #:	Telephone:
Department:	

Section B: For Completion by the Health Care Provider

Please complete the section below or provide a doctor's note and return it to the employee. Ensure that the form is signed and dated.

Health Care Provider's name (Print):		
Health Care Provider's business address:		
City:	State:	Zip Code:
Telephone:	Fax:	E-mail:

1. Is the employee now capable of performing the essential functions outlined in the attached job description?

- Yes, **without** restrictions
- Yes, **with** restrictions **(Employee must contact their supervisor to discuss work-related restrictions prior to returning to work)**

Please list the employee's work restrictions below. Limit your responses to the employee's ability to return to work and do not include the employee's medical condition or diagnosis.

The foregoing restrictions are: Permanent Temporary, until: _____ (indicate date)

No. *The employee remains unable to perform the essential functions of their role due to a serious health condition that required leave.*

2. Employee is released to return to work, effective: _____(indicate date)

Section C: Health Care Provider's Acknowledgement

I hereby certify that I have reviewed the employee named above and confirm that the information provided in this Return-to-Work notification is accurate and complete.

Health Care Provider Signature: _____ Date: _____

This form must be completed and sent to your direct supervisor and HR no later than two (2) business days prior to returning to work