USD 262 Valley Center Public Schools

Request to Return from FMLA Leave

Employee's Name	Social Security Number
School/Department	Position
Supervisor's Name	Home Telephone

This acknowledges that I am prepared to return to work from my FMLA Leave on ________________________

If my FMLA Leave was due to my illness, I understand that I must provide medical clearance signed by my medical provider indicating my fitness for duty and my release date.

____ ____________________________
Employee's Signature Date

Health Care Provider's Statement

This is to certify __________________________________ may return to work on ________________________.

Restrictions or limitations? ☐ None ☐ Yes

If yes, explain: ____

Signature of Health Care Provider:_____________________________________ Date:____________________

Print Name of Health Care Provider:____________________________________ Telephone:______________