

Intent to Return and Fitness for Duty/Medical Release FMLA - Form #3

SECTION 1: Instructions for the DEPARTMENT:

A copy of the essential job functions and regular work schedule/hours must be attached.

SECTION 2: To be completed by the EMPLOYEE:

Name of Employee (Print): _____

Employee Contact Information: _____ (phone) _____ (email)

If leave was for a continuous block of time and my health care provider has released me to return to work, I intend to return to work as scheduled. If no, I am stating I do not intend to return to work and I am resigning my employment with Indiana University.
 Yes No

I authorize do not authorize (check one) the health care provider identified below to provide the information requested on this form for the purposes of determining my fitness for duty and for a designated IU human resources professional to contact the health care provider to authenticate and/or clarify the information if needed. I understand that if I do not agree to this authorization, my return to work may be delayed or denied.

Employee's Signature: _____ Date: _____

An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.

SECTION 3: To be completed by the HEALTH CARE PROVIDER:

Instructions to the Health Care Provider: Please review the employee's work schedule and essential functions and answer the following:

Is employee able to perform the essential functions of the position that are attached? Yes No

If yes, the employee is fully released to return to work on _____ (date)

If no, the employee is released with restrictions to return to work on _____ (date). Please list the essential functions the employee is unable to perform until _____ (date) or permanently.

Additional comments:

Health Care Provider Information:

Signature: _____ Date _____

Printed name: _____