

CITY OF CLARKSVILLE
FAMILY AND MEDICAL LEAVE
RETURN TO WORK MEDICAL CERTIFICATION FORM

(Type or Print)

| PART I EMPLOYEE INFORMATION | |
|---|---------------------------------------|
| 1 Name: Social Security Number: | 2 Title: Department: |
| 3 Date Leave Commenced: | 4 Date of Return to Work: |
| 5 Employee's signature: _____ Date: _____ | |
| PART II TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER | |
| 6 <i>I certify that on _____ (date), I examined _____ (name of employee), and on the basis of my examination, this employee is ready to return to work and is able to perform the functions of his/her position.</i> | |
| Signed: _____ Date: _____ | |
| 7 Health Care Provider's Name, Address, and Telephone Number: | |
| PART III TO BE COMPLETED BY EMPLOYER | |
| Employer Remarks: | |

This form should be delivered or mailed to:
City of Clarksville., ATTN: Human Resources
1 Public Square, Suite 200
Clarksville, TN 37040