Family and Medical Leave Act (FMLA)

Return to Work Certification Form

Note: This form is for employees who are returning to work from being on leave for their own serious health condition as a fitness for duty clearance. *This form is not required if you have been on leave to care for a family member.*

SECTION I: For Completion by the EMPLOYEE

Employee Name:	**Date:** **Phone:**
Employee ID#:	**Department:**
Position:	**Supervisor:**
Classification: ☐ **Faculty** ☐ **Staff**	**Contract Length:** ☐ **12-Months** ☐ **9-Months** ☐ **Other**
Regular Work Schedule:	**Average Hours Per Week:**

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Please complete the following and return the form to the employee or to CFCC Human Resources. Please limit your answers below to the serious health condition for which the Employee has been on leave. Please be sure to sign & date the form on the last page. PLEASE PRINT CLEARLY.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Doctor's/Provider's Name: _____

Business address: _____

Type of practice/medical specialty: _____

Telephone: (_____)_____ **Fax:**(_____)_____

1. Is the Employee now able to perform those essential functions of their job that they were not previously able to perform because of the serious health condition for which the Employee has been on leave?

   ☐ No ☐ Yes ☐ Yes, with restrictions

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

3. If the Employee is released to work but is restricted in his or her ability to perform the essential functions of his or her job as a result of the serious health condition for which the employee has been on leave, please describe those restrictions:

   _____

   _____

4. The foregoing restrictions are:

   ☐ Permanent

   ☐ Temporary, until: _____ *(indicate date)*

_____ _____

Signature of Health Care Provider ***Date***

Submit completed form: Fax to: **910-362-7259;** OR scan and e-mail to: **HR@CFCC.edu**; OR mail to: CFCC Human Resources, 411 North Front St., Suite U-299, Wilmington, NC 28401. For questions call HR at **910-362-7312**.