

St. Louis County Government
FAMILY MEDICAL LEAVE
RETURN TO WORK MEDICAL CERTIFICATION FORM

Instructions for the County Employee:

1. Complete the top portion of this form.
2. Give it to your health provider (doctor) to complete the remainder of this form.
3. Give the completed form to your personnel representative by your return to work date.
YOU MAY NOT BE PERMITTED TO RETURN TO WORK UNTIL THIS FORM IS GIVEN TO YOUR PERSONNEL REPRESENTATIVE.

Your Name: _____

Your Employee Identification #: _____

Your Job Title: _____

Date Your Leave Began: _____ **Date You Plan to Return to Work:** _____

Your Signature: _____ **Today's Date:** _____

TO THE HEALTH CARE PROVIDER

This Medical Certification Form is required for the above St. Louis County employee to return to work after a leave of absence. Please complete this form and sign below.

Type of Practice: _____

Address: _____

Telephone No.: _____

Name: (Please Print) _____

I certify that on (date) _____, the above named St. Louis County employee is or will be able to resume to performing the functions of his/her position. Please check one of the boxes below:

Return to Work – No restrictions.

Return to Work – Restrictions (Please describe or attach a description.)

Health Care Provider's Signature: _____ **Date:** _____