NOTICE OF INTENTION TO RETURN FROM LEAVE

Name: _____

Supervisor: _____

Date Leave Commenced: _____

Date of Planned Return: _____

I understand that my restoration to employment is subject to the following conditions:

1. As a condition of restoration, each employee must provide a written certification from his or her health care provider that the employee is able to resume working.

2. Every attempt will be made to restore an employee returning from leave to his or her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits.

Employee's Signature: _____ Date: _____

I have examined _____ and can certify that he/she is fully able to resume working.

Health Care Provider's Signature: _____ Date: _____