School District of Holmen
1019 McHugh Road
Holmen, WI 54636
Phone: 608-526-6610
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FMLA Intent to Return and Fitness for Duty/Medical Release

SECTION 1: Instructions for HUMAN RESOURCES:

A copy of the job description, which includes the essential functions, must be attached. Also include the employees regular work schedule/hours.

SECTION 2: To be completed by EMPLOYEE:

You are required to have this fitness for duty certification completed by the health care provider who has knowledge regarding your reason for using FMLA. Submit this completed form to Human Resources at least two business days prior to your return to work. Your supervisor will then forward this form to Human Resources to be placed in your medical file.

Name of Employee (Print): _____

Department: _____ Supervisor: _____

If leave was for continuous block of time and my health care provider has released me to return to work:

( ) **Yes**, I intend to return to work as scheduled.

( ) **No**, I am stating I do not intend to return to work and I am resigning my employment with the School District of Holmen.

I ( ) authorize ( ) do not authorize (check one) the health care provider identified below to provide the information requested on this form for the purpose of determining my fitness for duty and for a designated SDH 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: _____

Hospital/Clinic: _____ Phone Number: _____