



REQUEST FOR RETURN TO WORK MEDICAL CERTIFICATION FORM

(Type or Print)

PART I EMPLOYEE INFORMATION	
1 Name: _____ Social Security Number: _____	2 Job Title: _____ Department: _____
3 Date Leave Commenced: _____	4 Date of Return to Work: _____
5 Requesting Supervisor's Printed Name: _____ Requesting Supervisor's Signature: _____ Work Telephone #: _____	
PART II TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER	
6 A) I certify that the above named employee was absent from work due to injury or illness for the following dates from _____ through _____. B) I certify that on _____ (date), I examined above named 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.	
Signed: _____ Date: _____	
7 Health Care Provider's Name, Address, and Telephone Number: 	

This form should be delivered or mailed to:

Salisbury University
Attn: Human Resources Department
1101 Camden Avenue
Salisbury MD 21801