STATE OF MARYLAND
FAMILY AND MEDICAL LEAVE
RETURN TO WORK MEDICAL CERTIFICATION FORM

(Type or Print)

PART I EMPLOYEE INFORMATION

❶ Name:	❷ Title: Department:
❸ Date Leave Commenced:	❹ Date of Return to Work:

❺ Employee's signature: ______________________________ Date: ______________________

PART II TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

❻ *I certify that on _______________ (date), I examined ______________________ (name of 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: _________________

❼ Health Care Provider's Name, Address, and Telephone Number:

PART III TO BE COMPLETED BY EMPLOYER

Employer Remarks:

This form should be delivered or mailed to:

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