University of Baltimore
Family and Medical Leave
Return to Work Certification

EMPLOYEE	Employee Name: Last First Middle Initial
	Department:
	Department Contact:
	Telephone:

HEALTH CARE PROVIDER	Please complete the following and return prior to the return to work date
	Please review the attached job description. Is the employee able to perform all the functions of his or her job? ☐ Yes ☐ No ☐ Yes, with restrictions or accommodations
	Please list any restrictions or describe accommodations which the department should consider:
	Are the restrictions: ☐ Permanent ☐ Temporary, until (date):
	Comments:
	Employee is released to return to work effective (date):
	Name of Health Care Provider:
	Specialty:
	Address of Health Care Provider:
	_____ _____ Signature of Health Care Provider Date

This form should be returned to:
Office of Human Resources
University of Baltimore
1420 N. Charles Street
Baltimore, MD 21201
Phone: 410.837.5410
Fax: 410.837.5408