Employee Accommodations and Absence Support Team
Return to Work Form
Fax #: (413) 573-8012
Submit Documentation: Upload FMLA Documents

Return to Work Program - Health Status Form

Part 1 - General Information

Employee's Name: Employee ID Number

Healthcare Provider Name: Facility Name:

Healthcare Phone Number: Healthcare Fax Number:

Part 2 - Completed by Employee

If an extension of leave is required or ADA Accommodation is needed, please contact **AskHR**

O I affirm my intent to return to work on: O I am requesting additional leave.

Employee's Signature: Date

Part 3 - Health Care Provider's Release to Return to Work – Completed by Health Care Provider

Please complete the information below. If the estimated return date exceeds the return date on the initial medical certification, an updated medical certification may be required.

O Employee is released to return to work at full duty, **without accommodation**, effective:

O Employee may resume work **with the following accommodation(s)** effective:

Expected duration of the accommodation is:

O Full-time **or** O Part-time Hours per day: Number of days per week:

Please list the employees' condition and any restrictions and job modifications the department may need to consider:

Indicate these restrictions are: O Permanent O Temporary Until Date:
(specify date, must be after employee has returned to work)

Health Care Provider's Signature Date