City of Milwaukee
FMLA Return to Work Certificate

Patient / Employee Information			
Patient / Employee Name:		**Employee ID #:**	**Date of Condition:**

A Return to Work Certificate will be required for continuous FMLA leaves of five or more days. The Return to Work Certificate should be sent to your departmental Leave Administrator at least two days before but no later than your return date. If such certificate is not provided, your return to active employment will be delayed until the certificate is provided.

TO BE COMPLETED BY ATTENDING PHYSICIAN

☐ Employee may return to work with no restrictions on _____ *(date)*.

☐ Employee may return to work with the following restrictions listed below. Restrictions are in effect from _____ to _____ *(dates only)*.

Patient ***CAN*** Carry/Lift			
	None	**1-4 HRS**	**5-8 HRS**
UP TO 10 LBS.			
11-20 LBS.			
21-50 LBS.			
51-100 LBS.			

Hand Restrictions				
HAND RESTRICTIONS	**NO USE**	**USE RIGHT ONLY**	**USE LEFT ONLY**	**USE BOTH**
OPERATE POWER TOOLS				
REPETITIVE WRIST				
ONE HAND WORK ONLY				

Patient's condition ALLOWS them to perform the following activities. (How many hrs each day)			
	1-4 HRS	**5-8 HRS**	**No Restrictions**
BEND			
TWIST/TURN			
REACH BELOW KNEE			
PUSH/PULL			
CLIMB			
SQUAT/KNEEL			
Must **SIT**			
STANDING			
WALKING			

☐ Employee is totally disabled and may not return to work from _____ to _____ *(dates)*.
Explanation:_____
_____

☐ Is the employee on any prescriptions that would cause them any physical or mental impairment that would affect the patient's ability to perform their job? ☐ No ☐ Yes,

> Please indicate Medication(s)_____

Physician Information			
Physician Name:		**Clinic / Facility Name:**	
Signature & Date:		**Clinic / Facility Phone #:**	

When completed, please return the completed form to the patient.