The University of North Carolina at Chapel Hill
Office of Human Resources

MEDICAL LEAVE – RETURN TO WORK FORM

NOTE: This form must be completed for any serious health condition of the employee prior to their return to work.

PART I: EMPLOYEE INFORMATION (to be completed by Employee)

Employee Name:		**PID #:**	
Dept Name:		**Dept #:**	
CB #:		**Work Phone:**	
Home Address:		**Home Phone:**	

PART II: MEDICAL RETURN TO WORK CERTIFICATION (to be completed by the Health Care Provider)

Name of Health Care Provider: ______________________

Name of Health Care Practice: ______________________

Address: ______________________

Phone: ______________ **Date of Examination:** ______________

Name of Employee: **Name of Patient:**

Date employee is released to return to work:	
Is the employee able to perform the essential functions of his/her position as of the return to work date?	☐ YES ☐ NO
Additional Comments:	

CERTIFICATION: I affirm that the information provided above is true and accurate to the best of my knowledge.

Signature-Health Care Provider: **Date:**

PART III: CERTIFICATION OF RETURN TO WORK (to be completed by HR Facilitator)

Date Leave of Absence (or reduced/intermittent schedule) **Began:**	
☐ **Date Employee Returned to Work at Regularly Scheduled Hours:** **NOTE:** If an employee is returning to work on a reduced or intermittent work schedule, do not complete this form. Instead, complete a new "Medical Leave – Leave Request Form" and check the "Supplement to Previous Request" box at the top right corner.	
Hours of Unused Shared Leave Donations to Be Returned: **NOTE:** Employee may retain up to 40 hours of donated leave.	
☐ **Employee IS NOT returning to work. Separation Date is:**	

HR Facilitator's Signature: **Date:**

FOR FACULTY, SPA AND EPA NON-FACULTY: Forward this document, along any other supporting documentation to:
Benefits Services Department, 104 Airport Drive, CB# 1045, Chapel Hill, NC 27599-1045.