

**GEORGETOWN UNIVERSITY
RETURN TO WORK MEDICAL CERTIFICATION FORM
FOLLOWING FAMILY/MEDICAL LEAVE**

I. EMPLOYEE SECTION

Name: _____ Position at Georgetown: _____

Date Leave Started: _____

Expected Return Date: _____

Employee Signature/Date: _____ / ____ / ____

II. HEALTH CARE PROVIDER

I certify that on ____ / ____ / ____ (date), the above named individual is able to resume performing the functions of his/her position with or without reasonable accommodation.

Signature/Date: _____ / ____ / ____

Type of Practice/Specialization: _____

Address: _____

III. EMPLOYER SECTION

Employer Remarks:

Department Signature/Date: _____ / ____ / ____