MERCER UNIVERSITY

Return to Work Medical Certification

PART I: TO BE COMPLETED BY EMPLOYEE

1. Name of Employee:	2. Employee's Position:
3. Date Leave Commenced:	4. Date Employee Can Return to Work:

5. Signature of Employee:

Signed: _____ Dated: _____

PART II: TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

6. I certify that on _____ _____ ,
(date) (name of employee)
is able to resume performing the functions of his/her position with or without reasonable accommodation.

Signed: _____ Dated: _____
(Signature of Health Care Provider)

7. Health Care Provider's Information:

Name: _____

Address: _____

Phone Number: _____