



**NOTICE OF INTENT TO
RETURN FROM FMLA LEAVE**

Employee Name: _____

Department: _____

Date Leave Began: _____ Date of Return: _____

I understand that my restoration to employment is subject to the following conditions:

1. If leave is for an employee's serious health condition, the employee must provide a written certification from a health care provider indicating the employee is able to resume working;
2. Every attempt will be made to restore an employee returning from leave to his/her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits;
3. If the FMLA leave was leave without pay (LWOP), the employee shall not be entitled to the accrual of any seniority or employment benefits during the period of leave;
4. The employee will make every attempt to notify the College at least two (2) working days in advance of the date of his/her intent to return from leave.

Employee Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED ONLY BY THE HEALTH CARE PROVIDER

I have examined the above named patient and certify that s/he is able to resume working:

Full-time _____ Other than full-time (please explain, including any restrictions)

Signature of Health Care Provider

Date

Telephone Number: _____