Washoe County – Physician's Return to Work Form
FMLA *(Family and Medical Leave Act)*

Employee Name: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

The above employee is hereby released to full duty, as s/he is able to perform the essential job functions as recorded on the accompanying "Essential Job Functions" form without limitation.

_____ _____
Health Care Provider (Please Print Name) Type of Practice

_____ _____
Address Telephone Number

_____
City, State, Zip Code

_____ _____
Signature of Health Care Provider Date