

## Intent To Return To Work and Medical Release Form

TO: \_\_\_\_\_  
(Supervisor's Name)

FROM: \_\_\_\_\_ Employee ID Number  
(Employee's Name)

- I affirm my intent to return to my normal duties  full-time  part-time on \_\_\_\_\_.
- I am requesting  modified  light duty.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

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### Medical Release

**This section must be completed by your doctor when returning to work after delivering a child, or due to your own serious health condition.**

The above named employee has been under my treatment for \_\_\_\_\_  
and is release to return to their normal work duties  Full-time  Part-time on  
\_\_\_\_\_ (date) If part-time duration of status \_\_\_\_\_ (date)

The employee is released to work their  modified duty  light duty  
until \_\_\_\_\_ (date)

For modified or light duty, describe the employee's limitations and restrictions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Print name of Health Care Provider

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
License Number Issued by  
Florida Board of Examiners

\_\_\_\_\_  
Health Care Provider's Address

\_\_\_\_\_  
Telephone Number

Please submit this form to your department two weeks prior to the end of your leave of absence. Your department is responsible for submitting this form to Human Resources along with a Personnel Action Form to return you from leave.