NOTICE OF INTENTION TO RETURN FROM LEAVE

Name: _____

Principal or Supervisor: _____

Date leave commenced: _____

Date of planned return: _____

I understand that my reinstatement is subject to the following conditions:

1. I must provide a written certification from my healthcare provider that I am able to resume working and can perform, with or without reasonable accommodation, the essential functions of my position.

2. Every attempt will be made to restore me to my original position. However, if my original position is unavailable, I will be placed in an equivalent position with equivalent pay and benefits. (This section may not apply to key employees.)

3. As an employee returning from family or medical leave, I shall not be entitled to the accrual of any time or employment benefits during my period of leave.

Date:_____ Employee's Signature:_____

STATEMENT OF HEALTHCARE PROVIDER

I have examined and can certify that he/she is fully able to resume working. If not fully able to perform the job, please attach a statement explaining the employee's fitness to return to work.

Date:_____ Healthcare Provider:_____

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