UNIVERSITY of NORTH TEXAS

Family and Medical Leave Update

Return Form To:
Lisa Garner, HR Representative
Human Resources Department, Benefits
PO Box 311010, Denton, Texas 76203
Phone: (940) 565-4253 Fax: (940) 565-4382

Employee Name: _____
Employee Job Title: _____
Patient's Name: _____
Relationship to Employee _____
Employee ID# _____

TO BE COMPLETED BY EMPLOYEE

I attest that I have full intention of returning to work. I understand that I am required to provide this medical update to my employer every 30 days for the duration of my FMLA absence. I also permit the University to contact my health care provider to seek additional or clarifying information that would assist in the appropriate documentation of my requested leave benefit(s).

_____ _____
Employee's Signature Date

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRACTIONER

It will be necessary for the employee: (check one)

☐**To work intermittently***; from the time period _____ to _____(specific dates or span of time);

☐**To work on a less than full schedule**, for _____(number of hours); from the time period _____ to _____ (specific dates or span of time); **OR**

☐ **To not work at all** as a result of the condition from the time period _____ to _____ (specific dates or span of time).

☐**The employee will be able to return to full duty on** _____

☐ **The employee will be able to return to light duty** on** _____

*Please attach copy of treatment schedule

**Please list restrictions_____
_____

_____
SIGNATURE OF PHYSICIAN OR PRACTITIONER: Date:_____

NAME OF PHYSICIAN OR PRACTITIONER (please print): _____

OFFICE PHONE: _____ OFFICE FAX: _____