UNT SYSTEM
Human Resources

FMLA Medical Update

Please download, complete and return to: UNT System Human Resources
FMLA Coordinator - Benefits
3550 Camp Bowie Blvd. EAD
Phone: 817-735-7650 Fax: 817-735-5495 Email: FMLA@untsystem.edu

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)

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

□ **Employee will be able to return to full duty on** _____

□ **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 _____

PRINT NAME OF PHYSICIAN OR PRACTITIONER _____

OFFICE PHONE _____ OFFICE FAX _____