ATTENDING PHYSICIAN'S REPORT
THE FAMILY AND MEDICAL LEAVE ACT

This is to certify that ____________________________
(Name of Employee)

Please check appropriate box:

No longer suffers from a serious health condition or disability and is able to work and perform all of the functions of his/her position without restriction as of ____________________.

OR

May return to restricted/alternative/modified duty from ______________ to ______________.

Comments/Restriction(s)

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

_____________________________________________________

Signature of Health Care Provider

Date

Completed form should be returned to: Human Resources
City of Racine
730 Washington Avenue, Room 2
Racine, WI 53403

Rev. 8/2009