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