

Request to Return from Medical Leave of Absence

Section I: Employee - Because my LOA was due to my illness, I understand that I must provide a medical clearance signed by my medical provider indicating my fitness for duty, my restrictions (if any) and my release date.

Employee Full Legal Name:		Department	
Employee Job Title			
Supervisor/Manager:			
Supervisor/Manager Contact Info:			
Employee Signature:		Date:	

Section II: For Completion by Health Care Provider

This form must be completed and submitted, **prior to returning to work**. Return by secure fax or email to:

Secure Fax: (205) 975-6900
employeehealth@uabmc.edu

This is to certify that _____ may return to work on _____.
 (Name of Patient) (Date of return work)

Restrictions or Limitations?

☐ NONE ☐ Yes

If yes, please explain:

SIGNATURE OF HEALTH CARE PROVIDER

DATE

PRINTED NAME OF HEALTH CARE PROVIDER

DATE