CASE WESTERN RESERVE UNIVERSITY EST. 1826

Department of Human Resources

CERTIFICATION BY A HEALTH CARE PROVIDER FOR RETURNING TO WORK

1. Employee Name: _____
   (please print)

2. Date the employee may return to work: _____

3. List below any restrictions or accommodations that are necessary and related to the employee's work:

4. Employee's signature: _____ Date: _____

5. Signature of
   health care provider: _____ Date: _____