



**CASE WESTERN RESERVE**  
**UNIVERSITY** EST. 1826

**RETURN TO:**  
**Email: leaves@case.edu or**  
**Secure fax: 216-368-8948**

## **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: \_\_\_\_\_