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: __________