FAMILY & MEDICAL LEAVE ACT (FMLA)

CERTIFICATION FOLLOW-UP FORM

PATIENT NAME_____

DATE_____, 20_____

The person named above was seen in my office on_____, 20_____.

As a result of that visit, it is my determination that he/she:

☐ Is unable to return to work at this time for the following reason: _____

_____

_____

☐ May return to work full-time on the following date:_____, 20_____

☐ May return to work on a part-time or intermittent basis effective_____, 20_____

☐ Restrictions, if any _____

_____

_____

Date of next appointment_____, 20_____.

Comments: _____

_____

_____

_____

Physicians Name_____ Physicians Signature_____

Phone Number_____ Fax Number _____

PLEASE FAX COMPLETED FORM TO MONTGOMERY COUNTY HUMAN RESOURCES AT (936) 788-8396