

RETURN-TO-WORK CERTIFICATION

EMPLOYEE NAME: _____

Please be advised that the above-referenced employee has been under my care and is able to return to work from his/her leave and perform the essential functions of his/her position on _____(date):

- without any restrictions
- with the following restrictions:

Signature of Health Care Provider

Name of Health Care Provider (please print)

Type of Practice

Telephone Number and Fax Number

Address, City, State and Zip Code

Date

PLEASE RETURN FULLY COMPLETED FORM TO: Johanny Tavares
Office of Human Resources
Fashion Institute of Technology
236 W. 27th Street, 11th Floor
New York, NY 10001-5992

or Confidential Fax: (212) 217-3651