

**City of Torrance
Return to Work Certification
FMLA/CFRA**

A. Employee Information (to be completed by employee)

Employee Name: _____ Employee ID Number: _____
Department: _____ Phone Number: _____
Employee Supervisor: _____
Leave Start Date: _____ Leave End Date: _____

B. Health Care Provider (to be completed by health care provider)

1) Please review the attached job description

Is employee able to perform the essential functions of this job? Yes No

If NO, please list the specific work restrictions:

The restrictions are: Permanent Temporary until: _____

Date employee is released to return to work: _____

Name of Health Care Provider

Health Care Provider Signature

Specialty

Date / /

Address

Telephone