

**EMPLOYEE MEDICAL LEAVE
RETURN TO WORK SELF-CERTIFICATION**

EMPLOYEE INFORMATION (PLEASE PRINT)

EMPLOYEE NAME

EMPLOYEE ID

LEAVE START DATE

SUPERVISOR NAME

DEPARTMENT/UNIT

RETURN DATE

I certify that my personal health care provider has cleared me to return to work on: _____
Return Date

Northwestern University reserves the right to request additional information from your personal health care provider regarding your clearance to return to work.

RESTRICTIONS

Check One

As of my Return Date, I will be able to return to work:

Without restrictions.

With restrictions, which will be in place until: _____
Restriction End Date

IMPORTANT: If you are subject to restrictions, or you have a disability that requires an accommodation, you must contact the Office of Civil Rights and Title IX Compliance as soon as possible to determine whether and under what conditions you may return to work. You may also be required to submit a certification from your health care provider to verify your restrictions or need for accommodation.

SIGNATURE

By signing below, I certify that the information set forth herein is accurate and complete.

Employee Signature

Date

Upon completion, return this form to HR Benefits askHR@northwestern.edu. If you do not complete and return this certification, you will not be permitted to return to work.