

FMLA CERTIFICATION FOLLOW-UP FORM

Patient _____

Date _____

The person named above was seen in my office on _____, 200__.
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: _____

May return to work on a part-time or intermittent basis effective _____

as follows _____

Restrictions, if any _____

Date of next appointment _____

Comments _____

Physician's Name

Physician's Signature

Phone Number

Fax Number

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