

**Stephen F. Austin State University  
Family & Medical Leave Act (FMLA)  
Medical Release**

Becky Garrett, HR Representative  
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**PART I-To be completed by employee**

Name of employee (please print or type):

Date leave commenced:

Employee's signature:

Date:

**PART II-To be completed by health care provider**

Date examined:

Effective as of \_\_\_\_\_ the above-named employee is:

\_\_\_\_ Released to work without restrictions; or

\_\_\_\_ Able to perform all essential functions (see attached description of essential job functions); or

\_\_\_\_ Released to work with restrictions until \_\_\_\_\_ or \_\_\_\_\_ permanently:

- Please describe any restrictions as they relate to the attached description of essential job functions:

Health Care Provider's Signature:

Date:

Health Care Provider's name (please print):

Type of practice/medical specialty:

Address:

Phone Number:

Fax Number:

**Return to work information:**

**In order to return to work you will need to provide this completed form to your department or Human Resources. Please notify Human Resources of your return to work. If you will need additional, intermittent FML due to your originally certified condition, please inform Human Resources upon your return to work.**

**If you need a reasonable workplace accommodation due to a disability in order to return to work, please contact Loretta Doty, Director of Human Resources, at 936-468-2304 or [dotylc@sfasu.edu](mailto:dotylc@sfasu.edu). Please make the request as soon as possible to allow sufficient time to review the accommodation request.**

**If you have any questions, please contact Becky Garrett at 936-468-1288, or by email at [garrettr@sfasu.edu](mailto:garrettr@sfasu.edu).**