

**Indiana University FMLA Form #3  
Release/Intent to Return to Work**

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**Department: Complete this section and give or send to employee:      Date:**

**This is to inform you that your Family/Medical Leave of Absence (FMLA) with Indiana University is scheduled to end.**

You are expected to return to work on \_\_\_\_\_ at \_\_\_\_\_.

**This form must be fully completed and presented to your department upon or prior to your return to work.**  
Return completed form to:

\_\_\_\_\_

**You are required to have your health care provider complete the bottom portion of this form, stating that you are fit to return to work before returning to work.     Yes     No**

(Bottom of form does NOT need to be completed if health care provider has indicated FMLA as an intermittent leave of absence, for care of a family member, or for placement of child.)

**If yes, attached is a list of *essential functions* of the position and the original page 2 of the Form 2E medical certification (and copies of recent medical updates,) to give to your health care provider.**

**Employee Name (Print):** \_\_\_\_\_ **Dept.** \_\_\_\_\_

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**Employee: Complete this section: (Please carefully read the section above.)**

**(If so noted above, your health care provider must complete the lower portion if you intend to return to work.)**

- \_\_\_ I intend to fully return to work on the date specified above. (see release below).  
\_\_\_ I am currently unable to fully perform all functions of my present position and am requesting an extension or assistance with temporary restrictions, as designated below (see statement below).  
\_\_\_ I do **not** intend to return to work as scheduled. I understand that by notifying you of this intention, I am resigning my employment with Indiana University.

**Employee's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Health care provider: Complete the following if the employee intends to return to work:**

- \_\_\_ The employee is **fully** released to return to work on \_\_\_\_\_ (date).  
\_\_\_ The employee is released to work on \_\_\_\_\_ (date), but **with** the following restrictions:  
\_\_\_\_\_ Until: \_\_\_\_\_ (date)

\_\_\_\_\_  
**(Signature and printed name of Health Care Provider)**

Type of Practice: \_\_\_\_\_ Date: \_\_\_\_\_