# Maternity Return to Work Medical Certification

**You will be required to this form PRIOR to being restored to employment.**

## TO BE COMPLETED BY EMPLOYEE

| Name | Employee ID | Date Leave Commenced |
|---|---|---|
| Job Title | Work Location | Date of Planned Returned to Work |

Employee Signature _______________ Date _______________

## TO BE COMPLETED BY THE HEALTH CARE PROVIDER

☐ I certify that ______________________________ is able to perform the essential functions of their position ***without restrictions or limitations*** effective ______________.

☐ I certify that ______________________________ is able to perform the essential functions of their position ***with restrictions or limitations*** effective ______________. Restrictions are as follows:

______________________________________________

______________________________________________

______________________________________________

Restrictions are in effect until ______________.

Physician's Signature _______________ Date _______________

Physician's Printed Name: ______________________________

Address: ______________________________

Telephone Number: ______________________________

## Please return to:

Anne Arundel County Public Schools, Division of Human Resources
Office of Intergrated Disability & Leave Management (IDLM)
2644 Riva Road, Annapolis, MD 21401
***Confidential Fax:*** 443-458-0140