TOYS"R"US
FMLA/MEDICAL LEAVE
RETURN TO WORK MEDICAL CERTIFICATION FORM

PART I: TO BE COMPLETED BY TEAM MEMBER

1. Name of Team Member: _____
First Name Middle Initial Last Name

2. Employee ID Number: _____

3. Team Member's Position: _____

4. Date Leave of Absence Commenced: _____

5. Date of Planned Return to Work: _____

6. Signature: _____ Date: _____

PART II: TO BE COMPLETED BY TEAM MEMBER'S HEALTH CARE PROVIDER

7. I certify that on _____, _____is able to resume
Return to Work Date Name of Team Member

performing the functions of his/her position **with**☐ OR **without**☐ reasonable accommodation.

If there are any required work restrictions, provide description and duration time below:

_____

_____

_____

8. Health care provider's name, address & telephone number:

_____

_____

9. Signature: _____ Date: _____

PART III: TO BE COMPLETED BY EMPLOYER:

10. Employer Remarks: _____

_____

11. Print Name: _____ Signature: _____ Date: _____