

**City of Torrance  
Return to Work Certification  
FMLA/CFRA**

**A. Employee Information** (to be completed by employee)

Employee Name: \_\_\_\_\_ Employee ID Number: \_\_\_\_\_  
Department: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Employee Supervisor: \_\_\_\_\_  
Leave Start Date: \_\_\_\_\_ Leave End Date: \_\_\_\_\_

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**B. Health Care Provider** (to be completed by health care provider)

1) Please review the attached job description

Is employee able to perform the essential functions of this job?  Yes  No

If yes, please list any restrictions or describe any accommodations which we should consider:

The restrictions are:  Permanent  Temporary until: \_\_\_\_\_

Date employee is released to return to work: \_\_\_\_\_

\_\_\_\_\_  
Name of Health Care Provider

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Date / /

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone