NEW HAVEN PUBLIC SCHOOLS

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## NOTICE OF INTENTION TO RETURN FROM LEAVE

### I. TO BE COMPLETED BY THE EMPLOYEE

Name ________________________________________ SSN __________-__________-__________

Address ______________________________________ State ________ Zip Code _______________

Primary Phone Number ________________________ Work Phone Number ___________________

Date Leave Commenced: ______________________ Date of Planned Return: __________________

Job title: ___________________________ Department/School: _______________________________

On leave due to: _____________________________________________________________________

I understand that my restoration to employment is subject to the following conditions:

1. As a condition of restoration, each employee must provide a written certification from his or her health care provider that the employee is able to resume full duty work.
2. Every attempt will be made to restore an employee returning from leave to his or her original position. If the employee's original position is unavailable, the employee will be placed in an equivalent position with equivalent pay and benefits.

Employee Signature: __________________________________ Date: __________________________

### II. TO BE COMPLETED BY THE PHYSICIAN

I have examined _____________________________________ and can certify that he/she is fully
(Print Employee Name)
able to resume working on a full time basis, without restrictions as of _________________________.

Name of Physician: _____________________________ Telephone Number: ___________________

Signature of Physician: _________________________________ Date: ________________________