UCF | Human Resources

UNIVERSITY OF CENTRAL FLORIDA

Intent to Return to Work Form

TO: _____
(Supervisor's Name)

FROM: _____ _____
(Employee's Name) Employee ID Number

Pursuant to my approved Leave of Absence Request, I affirm my intent to return to my normal work duties on _____.
(Date)

_____ _____
Employee's Signature Date

Medical Release

If you are returning to work from a full or reduced work schedule leave, and your absence was due to your own injury, illness, or pregnancy, please have your health care provider complete the following:

The above named employee is fully released to return to work on _____.
(Date)

Comments: _____
_____
_____
_____

If an extension of leave is required, please complete a new UCF Certification of Health Care Provider Form.

_____ _____ _____
Print Name of Health Care Provider Signature of Health Care Provider Date

_____ _____
Type of Practice License Number Issued by Florida Board of Examiners

_____ _____
Health Care Provider's Address Telephone Number

Please submit this form to your department two (2) weeks prior to the end of your leave of absence, or by the date given to you in your leave approval letter. Your department is responsible for submitting a copy of this Intent form to your HR Leave Coordinator. Your department must also send a Personnel Action Form (ePAF) to HR-Records upon your return to work.