

RETURN TO WORK CERTIFICATION

MR. / MRS. / MS. _____

Was under my care from _____ to _____

And will be able to return to work on _____

Are any job modifications required? NO YES

If YES, for how long? _____

Hours per day: _____

Please describe modifications: _____

Dr. _____

Dr. Signature _____

Date: _____

Address: _____

_____ Phone: _____

Fax this form to Unum Provident & GMU Human Resources

BEFORE you return to work:

Unum Provident : 800-447-2498

GMU Human Resources: 703-993-2601