

Maternity Leave Return to Work Form

Employee Information

- Employee Name: _____
- Employee ID: _____
- Job Title: _____
- Department: _____
- Supervisor/Manager Name: _____

Leave Details

- Start Date of Maternity Leave: _____
- End Date of Maternity Leave: _____
- Total Leave Duration: _____

Return to Work Details

- Planned Return to Work Date: _____
- Actual Return to Work Date: _____
- Requested Adjustments (if any):
 - ☐ Flexible Work Hours
 - ☐ Work-from-Home Option
 - ☐ Part-Time Schedule
 - ☐ Private Space for Nursing/Expressing Milk
 - ☐ Other (please specify): _____

Health Information (Optional, If Applicable)

- **Is a Medical Clearance Required?**

☐ Yes (Attach clearance form)

☐ No

- **Does the Employee Have Any Medical Restrictions?**

☐ Yes (If yes, provide details below)

☐ No

Employee Acknowledgment

I confirm that I am ready to resume my duties as per the agreed return-to-work plan. I have discussed and understand any required adjustments or accommodations.

Employee Signature: _____

Date: _____

Supervisor/Manager Review

- **Reviewed by:** _____

- **Title:** _____

- **Date:** _____

- **Comments:**

HR Department Use

- **Reviewed by (HR Representative):** _____

- **Date:** _____

- **Additional Notes:**