MONONA GROVE SCHOOL DISTRICT

Fitness for Duty Certification (Non-Workers Comp)

DIRECTIONS TO EMPLOYEE:

1. You may use this form to obtain a certification from your health care provider certifying that you are able to return to work.
2. Please have your physician fill out this form.
3. Please return this form to your supervisor before you return to work.

TO BE COMPLETED BY EMPLOYEE: (please print or type)

1. Name: _____
2. Current Assignment: _____
3. Current Building: _____
3 Date condition began: _____
4. Date condition ended (or is expected to end): _____
5. Date planned for return to work: _____

I understand that if I do not provide a requested fitness-for-duty certification to return to work, my employer may delay restoration until I submit the certification.

Employee's Signature_____ Date:_____

TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER: (please print or type)

7. I certify that the above-named employee is physically fit to meet the physical/mental requirements of returning to work. If accommodation is required, please list specific limitations to activity in the remarks section below.

_____ _____
Health Care Provider Print Name Date

_____ _____
Health Care Provider Signature Telephone

_____
Clinic Name

Area of Practice/Specialty (if any):_____

Remarks:

_____

_____

_____

Please return this form to: Monona Grove School District
Fax: 608-221-7688
Attn: Human Resources

Human Resources
5301 Monona Drive
Monona, WI 53716

October 2017