

FITNESS FOR DUTY CERTIFICATION (For FMLA)

You are required to provide this fitness of duty certification to the health care provider who is knowledgeable regarding your reason for using FMLA. Submit the completed form to Human Resources within at least two business days prior to your return to work.

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

Employee Name: _____ Location/Position: _____

Date Leave Began: _____ Expected Date of Return: _____

I understand that if I do not provide the 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)

I hereby certify that (patient's name) _____ was under my professional care for (nature of injury or illness) _____. I certify that I have read the job description enclosed with this form and that the above-named employee is physically fit to meet the physical/mental requirements listed in the description with or without (please circle one) reasonable accommodation. If accommodation is required, please list specific limitation to activity in the remarks section below. Employee released to return to work effective _____.

Signature of Health Care Provider: _____ Date: _____

Telephone

Address

Type of Practice: _____

Remarks:
