Waller Independent School District

20600 Fields Store Rd. ● Waller, TX 77484 ● Phone: 936-372-4064 ● Fax: 936-931-0396

FITNESS FOR DUTY CERTIFICATION

Dear Physician:

_____(employee) has taken Family Medical Leave for his/her own serious health condition. The serious health condition was _____.

The employee's position with Waller ISD is _____.

This form must be completed and returned to the Waller ISD Leave Specialist at least five (5) working days prior to employee's return to work.

This section is to be filled out by the employee's physician.

Based on employee's description of their job duties, is the employee able now to return to work?

- ☐ I certify that the employee named above is able to return to work as of _____ (date) **without** restrictions.
- ☐ I certify that the employee named above is able to return to work as of _____ (date) **with** restrictions, which are expected to last through _____ (date).
- ☐ I **cannot** certify that the employee named above is able to return to work.

If not able to return to work or employee has restriction(s), please fill out this section:

Based on the named employee's description of his/her job, what job functions would he/she be unable to perform?

_____

_____

_____

What, if any accommodations, would allow this employee to perform these job functions?
Please be specific with time, frequency, duration, etc.

_____

_____

How long do you anticipate he/she will need these accommodations?

_____

How may the employer reach you to clarify or authenticate the information provided on this form?

_____

_____

Physician's Printed Name: _____

Physician's Signature: _____

Date: _____