Fitness-for-Duty Certification

To: Date:

From:

Subject: Fitness-for-Duty Certification

Family and Medical Leave for your own serious health condition ends on (date) _____________. Prior to returning to work you must provide a Fitness-for-Duty Certification verifying whether you are able to return to work, if you have any job-related restrictions and the duration of any restrictions. Please take this Fitness-for-Duty Certification to your healthcare provider for completion. The district will use this Fitness-for-Duty Certification to determine if you are able to return to work after your leave.

Return the completed Fitness-for-Duty Certification to the district prior to the end of your Family and Medical Leave or by (date) ________________________.

Fitness-for-Duty Certification

Health Care Provider Completes this Section

Instructions: Please complete all sections in order for the district to determine if the employee is able to return to duty. The employee's position description or a list of essential duties (district specifies which) is attached to this form.

1. The employee is able to return to work full-time without restrictions: ☐ Yes ☐ No
   a. If yes, list the effective date ______________________.
   b. If no, complete the following:
      (1) The employee will be able to return to work with no limitation on (date) ___________.
      I certify that from (date) ____________________ to (date) ________________
      the above named employee will be:
      (a) ☐ Unable to perform the physical requirements of their work; or
      (b) ☐ Is medically incapacitated: ☐ Totally ☐ Partially**

      **If partially medically incapacitated, complete the following:
      (c) Number of hours per day employee is able to work ____________.
      (d) Number of days per week employee is able to work ____________.

(2) List any restrictions on the employee's work:

Printed name of health care provider____

Type of practice____

____
Signature, health care provider Date

Health care provider: Please return the completed form to the employee/patient.

Attached: Position description/description of essential duties (district specifies which).