Fitness-for-Duty Certification

Date: ______________________________

To: ______________________________

From: Payroll and Employee Services

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 health-care 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) ____________.
      (2) 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 __________________.

      (3) 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.