Clatskanie School District 6J

Code: **GCBDA/GDBDA-AR(7)**
Revised/Reviewed: 4/22/13

Fitness-for-Duty Certification

[***Instructions for the district for use of this sample form:*** *(THESE INSTRUCTIONS ARE NOT INTENDED TO BE INCLUDED WITH THE CERTIFICATION TO THE EMPLOYEE.) In order to condition an employee's return to work for the employee's own serious health condition on a fitness-for-duty certificate, the district must have notified the employee in the designation notice that a fitness-for-duty certification would be required before returning to work. If the district did not require a fitness-for-duty certification in the designation letter, once an employee comes back, if the district has concerns (based on evidence, not speculation) about the employee's ability to perform the job, the district can get a fitness-for-duty certification based on the Americans with Disabilities Act Amendments Act (ADAAA), rather than FMLA and OFLA. This is a sample 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) _____.

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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.

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