Riddle School District 70

Code: **GCBDA/GDBDA-AR(7)**
Revised/Reviewed: 5/21/14

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) ____________.

      (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).