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│      Santiam Canyon         │   Code: **GCBDA/GDBDA-AR(7)**
│   School District 129       │   Revised/Reviewed: 7/19/10; 6/10/15
│                             │   Orig. Code(s):  GCBDA/GDBDA-AR(6)
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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).