

**Warrenton Hammond
School District 30**

Code: **GCBDA/GDBDA-AR(7)**
Revised/Reviewed: 12/14/10; 6/13/17

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 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.

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