Worth County School District

FITNESS FOR DUTY CERTIFICATE

NOTE: For use only with Family & Medical Leave, Personal Medical Leave, and/or Leave without Pay due to medical reasons. Refer to the appropriate policies for more information on eligibility and restrictions. **PART III of this form must be completed by a Health Care Provider. A copy of this certificate must not be kept in a Department personnel file.**

PART I: EMPLOYEE INFORMATION

Employee Name:		**Employee #:**	
Job Title:		**Location:**	
Home Address:		**Work Phone:**	
City, State, Zip		**Home Phone:**	

PART II: MEDICAL AUTHORIZATION

AUTHORIZATION: I affirm that the information provided regarding my medical leave request is true and accurate to the best of my knowledge. I authorize the release of any medical information necessary to process this request.

Employee's Signature: _____ **Date:** _____

PART III: CERTIFICATION OF QUALIFYING CONDITION (to be completed by the Health Care Provider)

Date Leave of Absence (or reduced/intermittent schedule) **Began:**	
Date Employee Will Return to Work at Regularly Scheduled Hours: **NOTE:** *If returning to work on a reduced or intermittent work schedule, indicate here.*	
If Restricted Duty *(list all restrictions below in Comments)***, Date Employee May Resume Normal Job Duties Without Restrictions or Date of Follow Up Appointment for Reevaluation of Employee's Ability to Work:**	

Name of Health Care Provider: _____

Name of Health Care Practice: _____

Address: _____

Phone: _____ **Date of Examination:** _____

Name of Patient: _____ **Date of Birth:** _____

Brief Description of Condition:	**Date condition began:**
Is the employee able to perform the essential functions of his/her position as of the return to work date listed above? *If no, please list restrictions below in comments.*	☐ YES ☐ NO *(list restrictions below)*
Is the employee currently taking any medications that would hinder the performance of his/her essential job functions? *If yes, please list medication below in comments.*	☐ YES *(list medication below)* ☐ NO
Additional Comments: *(Please list all restrictions and/or medications in response to the above questions here.)*	

CERTIFICATION: I affirm that the information provided above is true and accurate to the best of my knowledge.

Signature-Health Care Provider: _____ **Date:** _____

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