



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

A Job Description listing all essential job duties is attached.
Please be sure that the job description is provided to the Health Care Provider along with this form.

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: <i>NOTE: If returning to work on a reduced or intermittent work schedule, indicate here.</i>	
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 (attached) as of the return to work date (above)? <i>If no, please list restrictions below in comments.</i>	<input type="checkbox"/> YES <input type="checkbox"/> NO (list restrictions below)
Is the employee currently taking any medications that would hinder the performance of his/her essential job functions? <i>If yes, please list medication below in comments.</i>	<input type="checkbox"/> YES (list medication below) <input type="checkbox"/> NO
Additional Comments: <i>(Please list all restrictions and/or medications in response to the above questions here.)</i>	
CERTIFICATION: I affirm that the information provided above is true and accurate to the best of my knowledge.	
Signature-Health Care Provider: _____ Date: _____	