Fitness for Duty Certification

Provide this fitness for duty certification to the health care provider who is knowledgeable regarding your reason for using FMLA. Submit the completed form to Human Resources within at least two business days prior to your return to work.

Employee Name: _____

Entity: _____

Job Title: _____

Date Leave Began: _____

Expected Date of Return: _____

TO BE COMPLETED ONLY BY HEALTH CARE PROVIDER

I have examined the above-named patient and certify that s/he is able to resume working:

☐ Full-time, or ☐ Less than full-time

Date patient can return to work: _____

(See attached job description)

☐ The patient can return to work with no restrictions.

☐ The patient can return to work with the following time, duty or other restrictions:

_____
_____
_____
_____
_____
_____

Expected duration of the restrictions:

_____
_____

_____ _____
Signature of Health Care Provider Type of practice/specialty

_____ _____
Date Telephone Number