FITNESS FOR DUTY CERTIFICATION AND NOTICE OF INTENT TO RETURN TO WORK

You are required to provide this fitness for duty certification and intent to return to work to the health care provider who is knowledgeable regarding your medical condition. **Submit the completed form to your supervisor prior to your return to work.** Your supervisor will then forward this form to Human Resources.

Employee Name: _____ Regularly Scheduled Work Hours:
Job Title: _____ _____ Days per Week
Department: _____ _____ Hours per Day
Supervisor: _____
Date Leave Began: _____ Expected Date of Return: _____

TO BE COMPLETED ONLY BY THE HEALTH CARE PROVIDER

I have reviewed the attached job description of the above named patient's duties. YES NO

I have examined the above named patient and certify that s/he is able to resume working (in relation to performing the duties/functions of their job):
_____Full-time, or
_____ Less than full-time

In relation to the patient's regularly scheduled work hours indicated above, the patient may return to work for the following maximum number of hours per day: _____ on _____ days per week.

Date patient is able to return to work: _____

_____ The patient can return to work with NO restrictions.

OR

_____ The patient can return to work with the following restrictions:

_____
_____
_____

Expected duration of the restrictions:

_____
_____

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

_____
Printed Name of Health Care Provider

_____ _____
Date Telephone Number