

Family and Medical Leave Fitness-for-Duty Certification Form



EMPLOYEE INFORMATION

| | | |
|-------------------|-----------|-----------------------------|
| FIRST NAME | MI | LAST NAME |
| | | |
| DEPARTMENT | | IMMEDIATE SUPERVISOR |
| | | |

HEALTH CARE PROVIDER

Please indicate the status for the employee's return to work status:

The employee is able to return to work with no restrictions

The employee is able to return to work with the following restrictions:

The employee is unable to return to work based on the attached job description

Return to work effective date: _____

Name of Health Care Provider: _____

Specialty: _____

Address: _____

Phone Number: _____

Signature of Health Care Provider _____ Date _____

INSTRUCTIONS TO EMPLOYEE

Please complete and return this form to your **immediate supervisor** and **Human Resources** prior to or on the day in which you will return to work.