Family and Medical Leave
Fitness-for-Duty Certification Form

THE UNIVERSITY OF ALABAMA IN HUNTSVILLE

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.