FITNESS FOR DUTY CERTIFICATION  
(Required of all employees returning from a Disability Leave of any kind)  
THIS FORM IS NOT COMPLETE WITHOUT A JOB DESCRIPTION LISTING PHYSICAL REQUIREMENTS 
OF THE POSITION ATTACHED

PART 1: TO BE COMPLETED BY EMPLOYEE

NAME: ___________________________  POSITION: ____________________________

DATE LEAVE BEGINS: ______________________

DATE PLANNED FOR RETURN TO WORK: ______________________

EMPLOYEE SIGNATURE: __________________________________ DATE: _______________________

PART 2: TO BE COMPLETED BY A HEALTH CARE PROVIDER

I certify that I have read the job description enclosed with this form and that the above-named employee is physically fit to meet the physical/mental requirements listed in the description with or without (please circle one) reasonable accommodation. If accommodation is required, please list specific limitations to activity in remarks section of this document.

SIGNED: ___________________________ DATE: _______________________

HEALTH CARE PROVIDER’S INFORMATION:

NAME: ___________________________

AREA OF PRACTICE/SPECIALTY: ___________________________

ADDRESS: _____________________________________________

PHONE: _____________________________

PLEASE LIST SPECIFIC RESTRICTIONS TO DUTY, IF ANY: (Please use extra paper if necessary.)

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REMARKS: __________________________________________________________

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Please return this form to Human Resources