FITNESS FOR DUTY CERTIFICATION
(Medical Leave of Absence)
Please Print or Write Legibly

Employee Name: _____

Please complete, including signature and date, the following information.

Notice to Physician or Practitioner:

- ☑ The employee named above has been off work from _____through _____ on Family Medical Leave, or
- ❑ The employee named above has been absent from work either intermittently or on a reduced schedule as follows (describe schedule and duration of schedule):
  _____
  _____
- ☐ The employee named above is on Non-FMLA Medical Leave from _____through _____.

The Serious Health condition that caused this leave was diagnosed as follows (from medical certification):

_____

_____

I hereby certify that this employee, based on the serious health condition diagnosed above,

- ❑ Is not able return to work at this time. Approximate release date _____.
- ❑ Is able to return to work on _____ without restrictions.
- ❑ Is able to return to work on _____ with the following restrictions.

❑ Lifting	❑ Pushing
❑ Pulling	❑ Bending
❑ Repetitive Motion	❑ Operating Moving Equipment
❑ Right Hand ❑ Left Hand Work Only	❑ Other (Please describe in detail on the back of this form.)

Physician or Practitioner Information (Please Print or Stamp):

Name: _____
Address: _____

_____

Telephone: _____

The above provided information is correct and based on reasonable medical certainty.

_____ _____
Signature of Physician or Practitioner Date

Restrictions

Please describe in detail the restrictions assigned to this employee: