FITNESS FOR DUTY CERTIFICATION

For Family and Medical Leave (FML)

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| **SECTION 1 – To be completed by the COLLEGE** |
| EMPLOYEE’S NAME (LAST, FIRST, MIDDLE INITIAL) |
|  |
| EMPLOYEE’S DEPARTMENT |
|  |
| COLLEGE CONTACT NAME |
|  |
| COLLEGE CONTACT’S MAILING ADDRESS |
|  |
| PHONE | FAX | E-MAIL |
|  |  |  |
| **SECTION II – To be completed by HEALTH CARE PROVIDER** |
| PLEASE COMPLETE THE FOLLOWING AN RETURN THE FORM TO THE COLLEGE CONTACT LISTED ABOVE PRIOR TO THE RETURN TO WORK DATE. Important: Please limit answers below to the serious health condition for which the employee has been on leave. |
| NAME OF HEALTH CARE PROVIDER | PLACE ADDRESS STAMP HERE |
|  |
| ADDRESS |
|  |
| 1. Is the employee now able to perform those essential functions of his or her job that he or she could not previously perform because of the serious health condition for which the employee has been on leave? [ ]  No [ ]  Yes [ ]  Yes, with restrictions |
| 2. The employee is released to return to work effective on this date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 3. If the Employee is released to return to work but is restricted in his or her ability to perform the essential functions of his or her job as a result of the serious health condition for which the employee has been on leave, please describe those restrictions: |
|  |
| 4. The foregoing restrictions are: [ ]  Permanent [ ]  Temporary, until this date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SIGNATURE** |
| SIGNATURE OF HEALTH CARE PROVIDER | DATE |
|  |  |