



Fitness for Duty Certification

Required of all employees returning from a Medical/Disability Leave of any kind.

Return to the Benefits Office King, Room 207

Part I: TO BE COMPLETED BY EMPLOYEE (Please Print or Type)	
<i>Please attach a job description listing physical requirements of your position to this form</i>	
Name:	Job Title:
Date Leave Begins:	University ID #:
Employee Signature: _____ Date: _____	
PART II: TO BE COMPLETED BY MEDICAL PRACTITIONER	
<p>1. I certify that I have read the employee's job description attached to this form and that the above-named employee is physically fit to meet the physical/mental requirements listed in the description (please check one) <input type="checkbox"/> <u>with or</u> <input type="checkbox"/> <u>without</u> reasonable accommodation.</p> <p>If accommodation is required, please list specific limitations to activity in remarks section (section 4).</p> <p>Signed: _____ Date: _____</p>	
<p>2. Healthcare Provider's Name:</p> <p>Address:</p> <p>Phone:</p>	<p>3. Area of Practice/Specialty (if any)</p>
<p>4. Please list specific restrictions to duty, if any: <i>(Please use extra paper if necessary.)</i></p>	
<p>5. Additional remarks:</p>	
<p>6. Date Released to Return to Work.</p>	

FOR OFFICE USE ONLY:
 Confirm Return Date: _____
 Notified Payroll on: _____
 Initials: _____