

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 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.
Is able to return to work without restrictions.
Is able to return to work with restrictions.

Table with 2 columns and 4 rows listing physical activities: Lifting, Pulling, Repetitive Motion, Right Hand, Left Hand Work Only, Pushing, Bending, Operating Moving Equipment, and 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

