Department of Human Resource Management

FITNESS FOR DUTY CERTIFICATION AND NOTICE OF INTENT TO RETURN TO WORK

You are required to provide this fitness for duty certification and intent to return to work to the health care provider who is knowledgeable regarding your reason for using FMLA. Submit the completed form to your supervisor within at least two business days prior to your return to work. Your supervisor will then forward this form to human resources to be placed in your medical file.

Employee Name:_____ BannerID: _____

Department:_____ Division: _____

Supervisor: _____

Date Leave Began:_____ Expected Date of Return: _____

TO BE COMPLETED ONLY BY THE HEALTH CARE PROVIDER

I have reviewed a job description, performance plan, or other written description of the above named patient's job duties. Yes No

I have examined the above named patient and certify that s/he is able to resume working:

☐ Full-time, or

☐ Less than full-time

Date patient is able to return to work: _____

☐ The patient can return to work with no restrictions.

The patient can return to work with the following time, duty, or other restrictions:

_____

_____

_____

_____

_____

Expected duration of the restrictions:

_____

_____

_____ _____

Signature of Health Care Provider Type of practice/specialty

_____ _____

Date Telephone number