Fitness for Duty Certification

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

Return to the Benefits Office, King Building, Room 207

Part I: TO BE COMPLETED BY EMPLOYEE (Please Print or Type) ***Please attach a job description listing physical requirements of your position to this form***	
Name:	Job Title:
Date Leave Begins:	University ID #:
Employee Signature:_____	Date:_____

PART II: TO BE COMPLETED BY MEDICAL PRACTITIONER	
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):*** ☐ with or ☐ without reasonable accommodation. ***If accommodation is required, please list specific limitations to activity in remarks section (section 4).*** Signed:_____ Date:_____	
2. Healthcare Provider's Name: Address: Phone:	3. Area of Practice/Specialty (if any)
4. Please list specific restrictions to duty, if any: *(Please use extra paper if necessary.)*	
5. Additional remarks:	
6. Date Released to Return to Work.	