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

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 Human Resources within at least two business days prior to your return to work.

Employee Name: _____

Department: _____

Job Title: _____

Date Leave Began: _____ Expected Date of Return: _____

TO BE COMPLETED ONLY BY THE HEALTH CARE PROVIDER

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