FAMILY AND MEDICAL LEAVE ACT
FITNESS FOR DUTY CERTIFICATION

To be completed by employer:

Employer Contact: Carole Nelson, Director, Human Resources

Employee Name: ________________________________

Employee’s job title: ________________________________

Check one:

☐ Employee’s essential job functions are:

________________________________________________________________________

________________________________________________________________________

☐ A list of essential job functions is attached.

☐ Job description is attached.

To be completed by Health Care Provider (Please limit responses to the condition for which the employee took FMLA leave):

Provider’s name and business address: ________________________________

________________________________________________________________________

________________________________________________________________________

Type of practice/specialty: ________________________________

Telephone: ________________________________ Fax: ________________________________
I have reviewed the essential job functions for this position and certify that 
_________________________ (Employee name):

☐ Is medically able to perform all essential functions of the position
☐ Is medically unable to perform all essential functions of the position.

If the employee is medically unable to perform one or more of the essential functions of the position, identify the job functions the employee is unable to perform:

____________________________________________________________________

____________________________________________________________________

I certify that ________________________ (Employee name):

☐ Is fit to return to full duty effective ________________________ (date).
☐ Is not fit to return to full duty until ________________________ (date).

____________________________________________________________________

Signature of Health Care Provider ___________________________ Date ____________