CHARLOTTESVILLE CITY SCHOOLS

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**