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# CHARLOTTESVILLE CITY SCHOOLS

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## FAMILY AND MEDICAL LEAVE ACT FITNESS FOR DUTY CERTIFICATION

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### 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.

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### 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**