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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: Dr. Keith P. Hubbard, Director of Human Resources

Employee's 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 number: \_\_\_\_\_ Fax number: \_\_\_\_\_

**I have reviewed the essential job functions for the position and certify that**  
\_\_\_\_\_ (Employee's 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's 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