FAMILY AND MEDICAL LEAVE ACT
FITNESS FOR DUTY CERTIFICATION

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.

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/speciality: ______________________________________________________________
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