FITNESS-FOR-DUTY CERTIFICATION

PART 1: To Be Completed by Employee (Please Type or Print.)			
Name: (First, Middle Initial, Last)			
Position Title:			
Supervisor:		Department:	
Date Leave Commenced:		Date of Planned Return to Work:	
Signature:			Date:

PART II: To Be Completed by Employee's Health Care Provider			
Physician's Name:			
Address:			
City:		State:	Zip:
Contact Name:		Title:	
Phone:	Fax:	E-mail:	

I certify that the above named employee is able to return to work on _____ (Date) with:

- ☐ No Restrictions
- ☐ The Following Restrictions:

Physician's Signature:	Date:

Part III: To Be Completed by Human Resources	
Received By:	Date Received: