FITNESS FOR DUTY CERTIFICATION

Employee Name: [Employee Full Name]

Employee ID: [ID Number]

Date of Absence: From [Start Date] to [End Date]

TO BE COMPLETED BY THE HEALTHCARE PROVIDER:

The above-named employee has been under my care for a medical condition that required a short-term disability leave of absence. I have reviewed the employee's essential job functions and hereby certify the following:

[ ] The employee is cleared to return to work **full duty** without restrictions effective: [Date]

[ ] The employee is cleared to return to work **with restrictions** effective: [Date]

Description of Restrictions (if applicable):

[List physical, cognitive, or schedule limitations here]

Duration of Restrictions:

These restrictions are expected to last until: [Date]

Healthcare Provider Information:

Provider Name: _____

Medical Specialty: _____

Phone Number: _____

Signature: _____ Date: _____

Instructions for Employee:

Please return this completed form to the Human Resources Department or your Disability Case Manager at least [Number] days prior to your scheduled return date.