Date: [Insert Date]

To: [Employee Name]
Employee ID: [Insert ID Number]
Position: [Insert Job Title]

Subject: Fitness for Duty and Return to Work Certification

Dear [Employee Name],

We are pleased to receive notification of your intent to return to work following your medical leave which began on [Leave Start Date].

To ensure a safe transition back to your professional duties, you are required to have your healthcare provider complete the "Fitness for Duty" section below. Please return this completed form to the Human Resources department on or before [Due Date].

Physician / Healthcare Provider Certification

Patient Name: [Employee Name]

Status (Check one):

- [ ] **Full Release:** The employee is fit to return to their full regular duties without any restrictions effective [Date].
- [ ] **Restricted Release:** The employee is fit to return to work with the following limitations effective [Date] until [End Date].

Specific Restrictions (if any):
[Insert details regarding lifting limits, standing duration, reduced hours, etc.]

Healthcare Provider Name: _____

Signature: _____

Date: _____

Medical Office Stamp/Phone: _____

Employer Acknowledgment:

Once this form is received and reviewed, [Company Name] will contact you to confirm your official return-to-work schedule. If you have any questions regarding this process, please contact [HR Contact Name] at [Phone Number/Email].

Sincerely,

[Your Name]
[Your Title]
[Company Name]