

FITNESS FOR DUTY CERTIFICATION

Date: [Date]

To: [Employer Name/HR Department]

Company: [Company Name]

Address: [Company Address]

Employee Name: [Employee Full Name]

Date of Birth: [DOB]

HEALTHCARE PROVIDER STATEMENT

I have examined the above-named employee and reviewed their job description. Based on my clinical evaluation, I certify the following:

The employee is fit to return to work full-time without any restrictions, effective [Date].

The employee is fit to return to work with the following restrictions, effective [Date] through [End Date]:

Restrictions: [Detail specific physical or cognitive limitations here]

The employee is not yet fit to return to work. A follow-up evaluation is scheduled for [Date].

Provider Comments (Optional):

[Insert any additional medical information relevant to work duties]

Healthcare Provider Information:

Name: [Provider Name/Title]

Practice Name: [Clinic/Hospital Name]

Phone Number: [Phone Number]

Signature: _____