



Code: GCBDA/GDBDA-AR (7)
Adopted:
1st Rdg:

Fitness-for-Duty Certification

To: _____ Date: _____

From: _____ Subject: Fitness for Duty Certification

Family and Medical Leave for your own serious health condition ends on (date) _____. Prior to returning to work you must provide a Fitness-for-Duty Certification verifying whether you are able to return to work, if you have any job-related restrictions and the duration of any restrictions. Please take this Fitness-for-Duty Certification to your healthcare provider for completion. The district will use this Fitness-for-Duty Certification to determine if you are able to return to work after your leave.

Return the completed Fitness-for-Duty Certification to the district prior to the end of your Family and Medical Leave or by (date) _____.

Fitness-for-Duty Certification Health Care Provider Completes this Section

Instructions: Please complete all sections in order for the district to determine if the employee is able to return to duty. The employee's position description is attached to this form.

1. The employee is able to return to work full-time without restrictions: ☐ Yes ☐ No
 - a. If yes, list the effective date _____.
 - b. If no, complete the following:
 - (1) The employee will be able to return to work with no limitation on (date) _____.
 - (2) I certify that from (date) _____ to (date) _____ the above named employee will be:
 - (a) ☐ Unable to perform the physical requirements of their work; or
 - (b) ☐ Is medically incapacitated: ☐ Totally ☐ Partially**
 - ** If partially medically incapacitated, complete the following:
 - (c) Number of hours per day employee is able to work _____.
 - (d) Number of days per week employee is able to work _____.
 - (3) List any restrictions on the employee's work: _____

Printed name of health care provider

Type of practice

Signature - health care provider

Date

Health care provider: Please return the completed form to the employee/patient.

Attached: Position Description