FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION

An employee on Family and Medical Leave because of his/her own serious medical condition must present this release to his/her supervisor prior to or on the day he/she returns to work. An employee may not work without this release.

TO: Health Care Provider

Our employee, _____, began a period of medical care leave for his/her serious health condition on _____.
(date employee commenced leave)

As a condition of return to work, the employee must be medically certified that they are able to return to work and perform all essential functions of their position. (NOTE: If you need a list of the employee's essential functions, one will be provided to you.)

1. Employee Name: _____
2. Employee's Job Title: _____
3. Date employee may return from leave_____ .
4. Please indicate with a check mark the status of the employee's release for duty.

   _____Full, unrestricted duty: This employee can perform all essential functions. (Skip question 5 and proceed to item 6.)

   _____This employee cannot perform the essential functions of his/her job.

   _____This employee can perform all essential functions, but may need accommodations or help with non-essential functions because of continued restrictions. (Complete question 5 and proceed to item 6).

5. If you are releasing the employee to modified duty, you must complete the following:

   a. Are there essential functions the employee still cannot perform? If so, list:

   _____

   b. Estimated date that employee will be able to return to unrestricted duty: _____

   c. Date of your next medical evaluation of the employee: _____

Indicate the exact work restrictions which apply to the employee at this time on the chart listed below.

(Complete this section if the employee is being released to modified duty.)

PHYSICAL EXAMINATIONS	FULL RESTRICTIONS	PARTIAL RESTRICTIONS	NO RESTRICTIONS

Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs)			
Standing (hrs)			
Sitting (hrs)			
Stooping (hrs)			
Kneeling (hrs)			
Repeated Bending (hrs)			
Climbing (hrs)			
Operating a motor vehicle, crane, tractor, etc.			
Other:			
Exposure Limitation (Specify):			

6. I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury at _____ , this _____ day of
(List City and State)

_____ > ___•
(month) **(year)**

Signature of Health Care Provider

Date

Print Name of Health Care Provider

Phone Number (include area code)

Type of Practice **License No.**

Address

City **State** **Zip**

cc: Personnel File