

FMLA FITNESS-FOR-DUTY CERTIFICATION

PART 1: To Be Completed by Employee (Please Type or Print.)

Name: (First, Middle Initial, Last)

Position Title:

Supervisor:

Department:

Date Leave Began:

Date of Planned Return to Work:

Signature:

Date:

PART II: To Be Completed by Employee's Health Care Provider

Physician's Name:

Address:

City:

State:

Zip:

Contact Name:

Title:

Phone:

Fax:

E-mail:

I certify that the above named employee is able to return to work on _____ (Date) with:

No Restrictions

The Following Restrictions:

Physician's Signature:

Date:

Part III: To Be Completed by Human Resources

Received By:

Date Received: