FITNESS-FOR-DUTY CERTIFICATION
FMLA LEAVE
(to be submitted prior to reinstatement)

Employee's Name: _____ Position: _____

Building: _____

Employee's serious health condition which caused him/her to take FMLA leave:

_____

_____

Date FMLA leave commenced: _____

Date FMLA leave is set to end: _____

Name of treating health care provider: _____

Medical practice (field of specialization, if any): _____

THE EMPLOYEE IS ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF HIS/HER JOB, WITH OR WITHOUT A REASONABLE ACCOMMODATION. **Yes** **No**

Any restrictions or accommodations necessary to allow the employee to return to work:

_____

_____

_____

_____

_____ _____
Health Care Provider's Signature Date

The Health Care Provider Authorization for Release of Information (see Form 4430.01 F5) or a similar HIPAA-compliant release form from the health care provider is required.

THIS IS A CONFIDENTIAL RECORD AND IT SHALL BE MAINTAINED AS SUCH
AS REQUIRED BY THE AMERICANS WITH DISABILITIES ACT.

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