FMLA FITNESS-FOR-DUTY CERTIFICATION

Employee: _____ School: _____

Status: Full-time: _____ Part-time: _____ On leave since: _____

You have my permission to contact the health care provider indicated on this certification for purposes of clarification.

Employee Signature _____ Date: _____

The following must be completed by the employee's health care provider

Effective as of _____ the above named employee is hereby certified as fit to resume the essential functions of his or her job as follows:

- ☐ Regular Schedule with No Restrictions
- ☐ Restrictions as noted (conditions and duration):

_____

_____

_____

_____

Restrictions are effective until _____ or until reevaluation on _____

- ☐ Intermittent leave is necessary. Please note the anticipated frequency and duration of leave needed, and any restrictions necessary: _____

_____

_____

_____

Intermittent leave is effective until _____ or until reevaluation on _____

Additional comments, if any: _____

_____

_____

_____

Name of health care provider: _____ Phone: _____

Clinic Name/Address: _____

Type of practice/specialty: _____

Provider Signature: _____ Date: _____