FITNESS FOR DUTY / RETURN TO WORK FORM

Instructions:

Immediate Supervisor: Give this form to the employee with the employee's up-to-date job description attached.

Employee: Have your health care provider review your attached job description and ask him/her to complete this form. The completed form must be returned to Human Resources by your health care provider *before returning to work* from a medical leave of absence or requesting a work accommodation.

Health Care Provider: Please review the attached job description for this employee, complete this form, and email this form to humanresources@flagler.edu (preferred) or fax it to (904) 826-8696. It cannot be returned by the employee.

Completed by Employee:

Employee name: ______________________________

Job Title and Department: ______________________________

Date the condition began: ______________________________

Completed by Health Care Provider:

Please check one of the following:

__ The employee is able to work a full, regular schedule with no restrictions, beginning ___________(date)

__ The employee is unable to return to work until __________(date)

__ The employee is able to return to work on a reduced schedule for ___ hours a day from _____(date) through_____ (date)

__ The employee is able to return to work with restrictions from______ (date) through______ (date).

Please indicate restrictions, if any, below for:

Standing (number of hours): ______________________________

Walking (number of hours): ______________________________

Sitting (number of hours): ______________________________

Lifting (number of pounds): ______________________________

Carrying (number of pounds): ______________________________

Use of hands (repetitive motions, pushing, pulling): ______________________________

Any other restrictions: (*If modified duty, please describe restrictions, as well as duration of restrictions*): ______________________

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Signature of Health Care Provider: ______________________________

**I hereby certify that I have examined the employee named above, and declare that the statements made in this Fitness for Duty Certification are true and correct.*

Printed Name of Health Care Provider: ______________________________

Address of Health Care Provider: ______________________________

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Phone Number of Health Care Provider: ______________________________

Date: ______________________________

Employees are responsible for any cost associated with the completion of this form by the Health Care Provider.