CANBY SCHOOL DISTRICT

Fitness for Duty Certification

Name: _____ **Location:** _____ **Date:** _____

Family and Medical Leave for your own serious health condition ends on (date)_____.

Prior to returning to work you must provide a Fitness-for-Duty Certification verifying whether you are able to return to work, if you have any job-related restrictions and the duration of any restrictions. Please take this Fitness- for-Duty Certification to your health care provider for completion. The district will use this Fitness-for-Duty Certification to determine if you are able to return to work after your leave.

Return the completed Fitness-for-Duty Certification to the district prior to the end of your Family and Medical Leave or by (date)_____.

Health Care Provider Completes this Form

Instructions: Please complete this form in order for the district to determine if the employee is able to return to duty. The employee's position description or a list of essential duties (district specifies which) is attached to this form.

The employee is able to return to work full-time without restrictions: ☐ Yes ☐ No

a. If yes, list the effective date:_____.

b. If no, complete the following:

The employee will be able to return to work with no limitation on (date)_____.

I certify that from (date)_____to (date) _____the above named employee will be:

☐ Unable to perform the physical requirements of their work; or

☐ Is medically incapacitated: ☐ Totally ☐ Partially**

**If partially medically incapacitated, complete the following:

Number of hours per day employee is able to work:_____.

Number of days per week employee is able to work:_____.

List any restrictions on the employee's work: _____

_____

_____

_____

_____

_____ _____

Printed Name of Health Care Provider Type of Practice

_____ _____

Signature - Health Care Provider Date

Health care provider: Please return the completed form to the employee/patient.
Attached: Position description/description of essential duties (district specifies which).