FITNESS-FOR-DUTY CERTIFICATION

Please ask your doctor to complete this form, and submit it to the Leave Coordinator in the HR office prior to your return. This form will remain **CONFIDENTIAL.**

Employee's Name: ____

Physician's Name: ____

Address: **Telephone:** ____________________

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Prognosis: ____

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Date Patient May Return to Work: ______________________________________

Work Restrictions: ____

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How long will work restrictions remain in force? ___________________________

Please list any medications that may affect employee's work performance.

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Physician's Signature **Date**