FITNESS-FOR-DUTY CERTIFICATION

Please ask your doctor to complete this form, and submit it to the Benefits Manger in the Human Resources Office prior to your return. This form will remain **CONFIDENTIAL.**

Employee's Name: _____

Physician's Name: _____

Address: **Telephone:** _____

_____

_____

_____

Prognosis: _____

_____

_____

Date Patient May Return to Work: _____

Work Restrictions: _____

_____

_____

How long will work restrictions remain in force? _____

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

_____

_____

_____

_____ _____

Physician's Signature **Date**