Office of the Lieutenant Governor (OLG)

Department of Culture, Recreation and Tourism (DCRT)

**FAMILY AND MEDICAL LEAVE ACT (FMLA)**

**FITNESS FOR DUTY CERTIFICATION**

|  |  |
| --- | --- |
| **Employee Name:** |       |
| **Personnel #:** |       |
| **Department/Section:** |       |
| **Current Job Title:** |       |

**SECTION A: DEADLINE FOR RETURN**

Our records indicate that your FMLA leave related to your own serious health condition ends on . **Prior to returning to work, you MUST return this form to your supervisor and the Human Resources Division.** By completing Section B. below, your healthcare provider is: (1.) verifying whether you are able to return to work; (2.) if you have any job-related restrictions; and (3.) the duration of any restrictions.

**SECTION B: TO BE COMPLETED BY HEALTHCARE PROVIDER**

Based on information provided in regard to the employee’s assigned job duties (via a written job description or orally by the employee), I certify that the above-listed employee’s fitness-for-duty is as shown below.

**Please indicate applicable work status:**

|  |  |
| --- | --- |
| 1. **[ ]  Employee is able to return to work**

 **without restrictions.** | **Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 1. **[ ]  Employee is partially incapacitated but is**

 **able to return to work with the following**  **restrictions:** | **Effective Date: \_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_** *From To* |
|  | 1. Work Hours/Schedule Restrictions: *(If left blank, it will be assumed that employee can resume his/her regular work schedule)*
* # of hour per day employee can work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* # of days per week employee can work: \_\_\_\_\_\_\_\_\_\_\_\_\_
1. Physical/Duty Restrictions: *(If left blank, it will be assumed that employee can resume all of his/her regularly assigned duties)*
* Specific physical/duty restrictions include:

(1) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(2) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(3) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(4) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 1. **[ ]  Employee is unable to perform the physical**

 **and essential functions of his/her job.** | **Effective Date: \_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_** *From To* |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*PRINTED Name of Health Care Provider Type of Practice*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature – Health Care Provider Date*