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*

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*Signature – Health Care Provider Date*