

Lincoln County School District

Code: **GCBDA/GDBDA-AR(6)**  
Revised/Reviewed: 6/14/16 (Effective 7/01/16)

**Fitness-for-Duty Certification**

To: \_\_\_\_\_

Date: \_\_\_\_\_

From: \_\_\_\_\_

Subject: Fitness-for-Duty Certification

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 healthcare 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) \_\_\_\_\_.**

**Fitness-for-Duty Certification**

**Health Care Provider Completes this Section**

**Instructions:** Please complete all sections 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.

1. 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:
    - (1) The employee will be able to return to work with no limitation on (date) \_\_\_\_\_.
    - (2) I certify that from (date) \_\_\_\_\_ to (date) \_\_\_\_\_ the above named employee will be:
      - (a)  Unable to perform the physical requirements of their work; or
      - (b)  Is medically incapacitated:  Totally  Partially\*\*

**\*\*If partially medically incapacitated, complete the following:**

- (c) Number of hours per day employee is able to work \_\_\_\_\_.
- (d) Number of days per week employee is able to work \_\_\_\_\_.

(3) 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).