

### Return to Duty - Fitness Certification

Employee Name: \_\_\_\_\_ Department: Biology  
Employee Status: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Date leave began: \_\_\_\_\_

You have my permission to contact the health care provider indicated below, for purposes of certification and authentication.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

#### **(Information below to be completed by health care provider)**

The above named employee, is hereby certified as fit to resume work duties as follows:

Effective date: \_\_\_\_\_

- Full time duties, no restrictions
- Full time duties, with the following restrictions (include conditions and duration):

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

Effective date: \_\_\_\_\_ End date: \_\_\_\_\_

- Part time duties, no restrictions
- Part time duties, with the following restrictions (include conditions and duration):

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

Effective date: \_\_\_\_\_ End date: \_\_\_\_\_

- Intermittent duties, with the following restrictions (include conditions and duration):

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

Additional comments, if any: \_\_\_\_\_

\_\_\_\_\_

Name of health care provider: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Type of practice/specialty: \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_ Date \_\_\_\_\_