Fitness for Duty Certification
Family and Medical Leave Act (FMLA)

Purpose of Form: An employee on a medical leave of absence under the Family and Medical Leave Act (FMLA) must present a fitness-for-duty certificate to their supervisor prior to returning to work. The FMLA guidelines are applied to employees who are on paid or unpaid leave. This form is for return to work purposes of a medical leave of absence due to an illness or injury, whether work or non-work related.

Instructions to the Employee: Please complete and sign this form before submitting to your health care provider. Please return the form to your department three days prior to your scheduled return date. Attached a copy of your position description

SECTION I - EMPLOYEE INFORMATION

Employee's Name:	Employee ID:
Supervisor:	Work Number:

PART A: MEDICAL RELEASE

I authorize the release of any medical information necessary to complete this form. I understand that if my release includes workplace restrictions related to my medical condition, it must reach my supervisor prior to my return to work date. I understand that my return to work date may be delayed so that my department can evaluate any identified restrictions. If restrictions are substantially limiting, are expected to continue longer than 3 months or are considered permanent, your return release will be referred to the Office of Equal Opportunity Programs (EOP) at (850) 599-3076.

Signature of Employee:	**Date**:

SECTION II - HEALTHCARE PROVIDER INFORMATION

Check one of the following:

☐ The employee is able to work a full, regularly scheduled day with no restrictions beginning _____ (date).

☐ The employee is unable to return for any work until _____ (date).

☐ The employee is able to return to work on a reduced schedule for _____ hours per day from _____ (date) through _____ (date).

☐ The employee is able to return to work with restrictions from _____ (date) through _____(date).

☐ Restrictions listed below are PERMANENT

PART A: WORK RESTRICTIONS

- ☐ Lifting / Carrying maximum ____ lbs.
- ☐ Pushing/pulling maximum ____ lbs.
- ☐ Kneeling/Squatting for more than ____ hrs. each day
- ☐ Standing/Walking for more than ____ hrs. each day
- ☐ Climbing stairs / ladders for more than ____ hrs. each day
- ☐ Reaching above shoulder R / L (circle)
- ☐ Grasping / squeezing R / L (circle)
- ☐ Typing / keyboarding / entering data for more than _____ hours each day

PART B: OTHER RESTRICTIONS

_____

_____

_____

_____

PART C: OTHER INSTRUCTIONS

_____

_____

_____

_____

Based on my personal evaluation of the patient's condition, the above information is accurate and complete.

Signature of Health Care Provider:	**Date**:
Printed Name:	
Type of Practice:	
Address:	
Phone:	**Fax:**