



Fitness For Duty Certification

Instructions to Employee: Please complete this section before giving this form to your health care provider. Return this form to Human Resources before you return to work.

Employee Name _____ Employed D _____

Instructions to Department/Institution: Attach the job duty statements from the official Position Description Questionnaire (PDQ). This completed form is to be placed in a separate, confidential medical file with limited access from the usual personnel files for Family Medical Leave Act (FMLA) purposes and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. 1635.9 if the Genetic Information Nondiscrimination Act applies.

Instructions to Health Care Provider: Please complete this form when the employee is seeking your release to return to work or when requesting workplace accommodation. Do not provide information about genetic tests, as defined in 29 C.F.R. 1635.3(f), genetic services as defined in 29 C.F.R. 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. 1635.3(b). Please be sure to sign the bottom of this form and return to the employee.

1. Date the condition began: _____

2. a) 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 from _____ (date) through _____ (date).

The employee is able to return to work with restrictions as of _____ (date).

b) Please indicate restrictions:

Activity	Able to Perform	Not Able to Perform	Other to
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Activity	Full Restrictions	No Restrictions	Partial Restrictions(Please Explain)
Lifting or carrying objects			
Pushing/pulling objects			
Bending/stooping/squatting/twisting			
Kneeling			
Crawling			
Sitting			
Standing			
Walking			
Climbing stairs Working/climbing on elevated equipment(ladders,			