FITNESS-FOR-DUTY CERTIFICATION

PART 1: To Be Completed by Employee (Please Type or Print.)			
Name: (First, Middle Initial, Last)			
Position Title:			
Supervisor:		Department:	
Date Leave Commenced:		Date of Planned Return to Work:	
Signature:			Date:

PART II: To Be Completed by Employee's Health Care Provider			
Physician's Name:			
Address:			
City:		State:	Zip:
Contact Name:		Title:	
Phone:	Fax:	E-mail:	

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I certify that the above named employee is able to return to work on _____ (Date) with:

☐ No Restrictions

☐ The Following Restrictions:

Physician's Signature:	Date:

Part III: To Be Completed by Human Resources	
Received By:	Date Received: