FITNESS FOR DUTY FORM:

For Family and Medical Leave Act (FMLA)

Webster Groves School District

You are required to have this fitness for duty certification completed by the health care provider who has knowledge regarding your reason for using FMLA. Please have your health care provider complete this form and return to Human Resources at least two (2) business days prior to your return to work via fax (314) 918-4671.

TO BE COMPLETED BY EMPLOYEE (Please print)

Name: _____ Position: _____

Building: _____ Building Administrator: _____

Date Leave Began: _____ Expected Date of Return: _____

I authorize the health care provider identified below to provide the information requested on this form for the purpose of determining my fitness for duty. Furthermore, I understand a designated WGSD Human Resources professional may contact my health care provider to authenticate and/or clarify any information related to my fitness for duty, as needed.

Employee's Signature: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

Is the employee able to perform all of the functions of his/her regular job? ☐ Yes ☐ No

Is the employee able to return to work without posing a significant risk or substantial harm to him/herself or others? ☐ Yes ☐ No

Is the employee able to work his/her normal work schedule? ☐ Yes ☐ No (Please indicate schedule modification.)

_____

☐ Full/unrestricted duty, effective: _____

☐ Restrictive duty, effective: _____ next evaluation date: _____

Please indicate any accommodations the employee may need: _____

_____

_____

☐ The employee is not released to return to work. Next evaluation date will be: _____

I hereby certify I have examined the employee named above, and declare that the statements made in this Fitness for Duty Certification are true and correct:

Signature of Health Care Provider: _____ Date: _____

Health Care Provider (Print Name): _____

Address: _____ Phone Number: _____

Type of Practice/Medical Specialty: _____