Fitness For Duty Status & Certification Form

St. Olaf College

Scan/Email: grant2@stolaf.edu | Fax: 507-786-3960

Employee Name: _____ **Position Title:** _____

NOTICE TO EMPLOYEE

In connection with the Family Medical Leave Act (FMLA) leave requested for your own serious health condition and the FMLA Designation Notice provided by St. Olaf College, you are required to provide this completed Fitness For Duty Certification Form:

- ☐ On an intermittent basis (maximum once every 30 days) _____
- ☐ Prior to your returning to work on or approximately ____ / ____ / _____

You are responsible for having your physician evaluate your ability to perform the essential job functions contained within your job description and certify your fitness for duty by completing all items and signing below. You will not be reimbursed for any time, travel or expenses related to obtaining fitness for duty certification. You must return this completed Fitness For Duty Status & Certification Form to the Human Resource as requested or the reinstatement of your position may be delayed or denied under the FMLA. Please note that additional clarification and/or information may need to be obtained from your doctor prior to you being partially/fully reinstated.

TO BE COMPLETED BY PHYSICIAN ONLY: *(Please refer to the attached job description.)*

Physician Name (Print): _____

Clinic/Hospital Name: _____

Direct Phone Number: _____-_____-_____

1. Is the employee able to resume work? ☐ Yes ☐ No
2. On what date is the employee able to safely Return To Work (RTW)? ____ / ____ / _____
3. Will employee be able to perform <u>all</u> essential job functions on RTW date? ☐ Yes ☐ No
4. Are there <u>any</u> essential job functions unable to be performed on RTW date? ☐ Yes ☐ No
   4a. If yes, please specify:

   4b. Anticipated date employee can be restored to <u>full duty</u>? ____ / ____ / _____
5. Are there any other restrictions/instructions the employer should be aware of? ☐ Yes ☐ No
   5a. If yes, please specify:

   5b. Anticipated date when <u>all</u> restrictions can be removed? ____ / ____ / _____

Physician Acknowledgement

I certify that I have examined the employee named above and declare that the statements made on this Fitness For Duty Status & Certification Form are true and accurate. I agree to obtain the necessary approval from the employee to provide St. Olaf the information contained on this Fitness For Duty Status & Certification Form and any further items needed for this certification.

_____ _____

Physician Signature Date

Questions should be directed to Travis Grant in the St. Olaf Human Resource Office at 507-786-6689.