SAMPLE
FITNESS FOR DUTY CERTIFICATION
_____ COUNTY _____ DEPARTMENT

This section to be completed by the employer:

EMPLOYEE:	POSITION:
ESSENTIAL DUTIES AND RESPONSIBILITIES: OTHER DUTIES AND RESPONSIBILITIES:	

This section to be completed by the employee's Health Care Provider:

I have read the duties and responsibilities for the employee's position described above. It is my professional medical opinion that:

The employee ☐ IS ☐ IS NOT able to perform the duties and responsibilities of the position and return to work full time without restrictions.

If not, complete the following:

The employee will be able to return to work full time without restrictions on (date) _____.

Between the dates of _____ and _____ the employee may return to work with the following restrictions (please state the employee's limitations in terms of the duties and responsibilities the employee may be unable to perform adequately):

Does this employee's performance of the duties and responsibilities of the position as described pose any danger to the health and/or safety of the employee or others?

☐ Yes

☐ No

If YES, please explain:

I hereby certify that I have examined the employee named above and that the foregoing responses are true and complete in my professional medical judgment to a reasonable degree of medical certainty.

Signature of Health Care Provider	Type of Specialty/Practice
Address	Telephone Number
	Date