1234 Market Street, 16th Floor
Philadelphia, PA 19107

FITNESS FOR DUTY CERTIFICATION

Employee's Name: ____

Date: _______________________

You have my permission to contact the healthcare provider indicated on this certification for purposes of authentication and clarification related to this serious health condition, if necessary.

Signed ____________________________________ Date: ______________

(Information below to be completed by healthcare provider)

Effective as of _____________________________________, the above-named employee is:
(date)

❑ Released to work without restrictions; *or*

❑ Able to perform all essential duties (see attached description of essential job duties); *or*

❑ Released to work with restrictions (please describe restrictions as they relate to the attached description of essential job duties):

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Name of healthcare provider: _______________________________________

Address: ____

Telephone: ________________________

Type of practice/specialty: ____

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Signed ___________________________________ Date: ________________