COMMONWEALTH OF MASSACHUSETTS

FITNESS-FOR-DUTY CERTIFICATION

DIRECTIONS TO EMPLOYER:
1. Please attach the employee's job description to this form, including the essential functions of his/her position.
2. Give this form and the job description to the employee to obtain the requisite medical certification.

DIRECTIONS TO EMPLOYEE:
1. You may use this form to obtain a certification from your health care provider certifying that you are able to return to work.
2. Please have your physician fill out this form.
3. Please return this form to your supervisor before you return to work.

TO BE COMPLETED BY EMPLOYEE: (please print or type)

1. Name 2. Department / Agency

3 Date condition began

4. Date condition ended (or is expected to end)

5. Date planned for return to work

I understand that if I do not provide a requested fitness-for-duty certification to return to work, my employer may delay restoration until I submit the certification.

Employee's Signature_____ Date:_____

TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER: (please print or type)

7. I certify that I have read the job description enclosed with this form and that the above-named employee is physically fit to meet the physical/mental requirements listed in the description **with** or **without** (please circle one) reasonable accommodation. If accommodation is required, please list specific limitations to activity in the remarks section, below.

_____ _____
Signature of Health Care Provider Date

_____ _____
Telephone

_____
Address

Area of Practice/Specialty (if any):_____

Remarks:

_____

_____

_____

Please return this form to: _____ FOR OFFICE USE ONLY

_____ Confirm Return Date:_____

_____ Notified Payroll On:_____

_____ Initials:_____