



## Fitness for Duty Certification

Division of Human Resources: Benefits Department  
1020 East Wendover Avenue. Suite 109 Greensboro, NC 27411  
Phone: (336) 285-3790 Fax: (336) 334-7477

**Part I. To be completed by Employee**

<b>Employee Information</b>	
Name:	Position:
Date Leave Begins or Began:	
FMLA 12 Week Expire Date:	
Signature:	Date:

**Part II. To be completed by Employee's Healthcare Provider**

<b>Healthcare Provider Information</b>	
Name & Address:	
Date Employee Can Return to Work:	
Telephone Number:	Fax Number:
Area of Practice/Specialty (If any):	Date:
<p>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: (please select one)</p> <p><input type="checkbox"/> With Reasonable Accommodations</p> <p><input type="checkbox"/> Without Reasonable Accommodations</p> <p>If accommodation is required, please list specific limitations to activity below.</p>	
Signature:	Date:

**TO BE COMPLETED BY DIVISION OF HUMAN RESOURCES**

Confirm Return Date:	Date Payroll Notified:	As of Date:
Signature :	Date:	