# Fitness for Duty Certification

To employee: Complete Part 1 and arrange for your health care provider to complete and return Part 2. The completed form must be received by Academic Human Resources seven (7) calendar days prior to your return to work. Completed forms should be submitted directly to Academic HR and not your college, school, or department.

To Health Care Provider: An employee on a medical leave under the Family and Medical Leave Act (FMLA) and/or Faculty Sick Leave Policy must present this Fitness for Duty Certification prior to returning to work. Complete Part 2 to certify the employee’s ability or inability to return to work and submit it to the Academic Human Resources office (contact information is listed below).

## PART 1 – to be completed by employee (please print)

I am requesting to return to work on ________________

I hereby authorize the Health Care Provider named below to release information related to my return to work:

Employee signature ___________________________________________________________ Date ______________________

## PART 2 – Medical Facts: to be completed by Health Care Provider

Date of Most Recent Medical Examination: ________________________________

Please check the status of the employee’s release for duty:

- [ ] Full, unrestricted duty without work restrictions, effective (date)_________________

- [ ] Modified duty, effective (date) _______________________ ; next evaluation date ______________________________

Please describe any and all work restrictions, in detail:

Are these restrictions [ ] Permanent [ ] Temporary until (date)______________________________

[ ] Not released for any type of duty due to physical or mental limitations; next evaluation date will be ______________________________

## Health Care Provider Information

I hereby certify that the information provided in Part 2 is true and correct.

Name (please print) ___________________________________ Specialty ______________________________

Business Address ____________________________________________________ Phone ______________________

Health Care Provider Signature_____________________________________ Date ______________________

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This document may be submitted confidentially to:
University of Washington
Academic Human Resources
Box 351270
Seattle, WA 98195-1270
Email: apleaves@uw.edu
Fax (206) 221.4622

AHR USE ONLY

Reviewed by (initials) ___________ Date: ___________