

Creighton UNIVERSITY

Fit For Duty Certification

Name: _____

Supervisor: _____

Date leave began: _____

Date of planned return: _____

I understand that my return from leave is subject to the following condition:

- As a condition of returning to work, each employee must provide a written certification from his or her health care provider that the employee is able to resume working.
- If restrictions prevent me from performing essential functions of my job, return to work may not be allowed.

Employee Signature

Date

I have examined _____
(employee name)

and can certify that:

_____ he/she is fully able to resume working without restrictions.

_____ he/she is able to resume working with the following restrictions (please list any restrictions and possible duration on the back of this sheet).

Health care provider's signature

Date

Health care Provider's Name (please print)

Phone number

(Please return a copy of this form to the Human Resources Department)