CITY OF BROCKTON

Department of Human Resources

45 School Street, 2nd Floor Brockton, MA 02301 P. (508) 580-7820 F. (508) 580-7133

FAMILY & MEDICAL LEAVE ACT (FMLA) FITNESS FOR DUTY CERTIFICATION

DO NOT PROVIDE MEDICAL DOCUMENTATION TO YOUR SUPERVISOR – SUBMIT DIRECTLY TO HR DEPARTMENT

Prior to returning to work, you must provide a **Fitness for Duty Certification** verifying whether you are able to return to work, if you have any job-related restrictions and the duration of any restrictions. **Your physician must submit this completed Fitness for Duty Certification form directly to Human Resources** as requested, **NO LESS than 3 - 5 business days prior** to your return to work or your return to work may be delayed or denied under the FMLA.

SECTION A: TO BE COMPLETED BY EMPLOYEE

I give permission to my health care provider to supply the City of Brockton, Human Resources Department with the requested data for the purpose of determining whether I am fit to return to work after my FMLA leave. In addition, I authorize my health care provider to provide to Human Resources data regarding my fitness to return to work for the purposes of clarifying or authenticating information previously provided, or to provide missing information. I understand that the data I provide will be accessed by authorized personnel whose jobs reasonably require access, such as the Human Resources Director and/or desginee.

Employee Name/**PRINT:**______________________________ Employee ID: ________________________

Employee Signature:______________________________ Date: ________________________

SECTION B: TO BE COMPLETED BY HEALTH CARE PROVIDER

The employee is required to provide a complete and sufficient **Fitness for Duty Certification**, completed by their health care provider, prior to returning to work from FMLA leave.

This certification is being sought only with regard to the particular health condition that caused the employee's need for FMLA leave.

Employee's job description must be attached. Please consider these essential functions as you review the employee's fitness for duty.

Date of Medical Examination: ____________________ **DATE OF FOLLOW UP APPOINTMENT:** ____________________

I certify that, with regard to the particular health condition that caused the need for the employee's FMLA Leave, the employee is fit for duty and able to resume work, as indicated below:

☐ **Full/unrestricted duty,** effective:____________________ ☐ **Modified/Light duty, Begin:** __________ **End:** __________

If modified or light duty, please describe restrictions, indicating # of allowed work hours per day and/or week, if applicable OR exact physical limitations, as per requirements of employee's position and responsibilities on attached job description. (Please attach separate sheet if required):

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☐ The employee is **NOT** released to return to work. **DATE OF FOLLOW-UP APPOINTMENT:** ____________________

Provider name/**PRINT:** ______________________________ Phone number: ____________________

Provider signature: ______________________________ Date: ____________________

Address: ____

I hereby certify that I have examined the employee named above, reviewed the essential functions listed in the job description and declare that the statements made in this Fitness for Duty Certification are true and correct.