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 Human Resources 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 set 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, concur with the information provided by the employee above or note any changes below, and that the above-named employee is able to meet the essential functions of the position as listed in the description **with** or **without** (please circle one) reasonable accommodation and is able to return to work on _____.

Please note that if a reasonable accommodation is requested, the Employer will also **require** certain information to show that the employee is a qualified individual with a disability and thus, entitled to a workplace accommodation and that the accommodation requested is reasonable. **This information should be included below or attached to this form and includes the following**:

- the specific nature of the employee's disability;
- signs of manifestation of the employee's disability;
- identification of all other life activities or tasks (i.e.; personal hygiene, household chores, other professional work activities, caring for family members, exercise, etc.) the employee is unable to perform or is inhibited in performing due to the employee's disability;
- identification of those essential functions of the employee's position that the employee is currently unable to perform due to the disability;
- a detailed and specific explanation of the accommodation(s) requested; and
- a reasonable assurance that the employee will be able to perform all essential functions of the position, with the requested accommodation upon the employee's return to work.

Health Care Provider Remarks:

Signature of Health Care Provider Date

Name of Health Care Provider (typed or printed)

Address Telephone

Area of Practice/Specialty (if any):

Please return this form to

FOR OFFICE USE ONLY

Confirm Return Date:

Notified Payroll On:

Initials: