FITNESS FOR DUTY CERTIFICATION

Any personal at home injury or extended personal medical absence requires a Fitness for Duty Certification. This completed form must be returned to Human Resources at least 2-3 business days prior to returning to work. The employee should have provided a copy of their published Job Description for review by their health care provider in conjunction to this form's completion.

| EMPLOYEE SECTION |

EMPLOYEE NAME: _____ DEPARTMENT: _____

CONTACT: (EMAIL/PHONE) _____ SUPERVISOR: _____

I authorize my health care provider to provide the information on this form for the purpose of determining my fitness for duty. I authorize that a designated Kitsap County Human Resources professional may contact the health care provider to authenticate and/or clarify information, if needed. I understand if I do not provide a completed Fitness for Duty certification, my return to work may be delayed or denied. I have provided my physician a copy of my job description.

EMPLOYEE SIGNATURE: _____ DATE: _____

| HEALTH CARE PROVIDER ONLY |

• **Complete this form ONLY when the employee is capable of returning to work** •

Please review the employee's work schedule, essential functions, working conditions and physical requirements listed in their job description and answer the following:

Effective as of _____, the employee is certified to resume work duties as follows:

☐ **No Restrictions** on essential duties: ☐ Full-Time ☐ Part-Time

☐ **With Restrictions** on essential duties: ☐ Full-Time ☐ Part-Time

Please list the essential functions, working conditions and physical requirements the employee is **UNABLE** to perform:

CDL Drivers must submit a DOT Medical Certificate with this Fitness for Duty Certification*

If released to Part-Time work, employee is able to work _____ hours per day, _____ days per week.

Estimated date the employee will be able to return to Full-Time work with no restrictions: _____

Is follow-up treatment necessary? ☐ No ☐ Yes, next follow-up appointment: _____

NAME OF TREATING PHYSICIAN: _____

SIGNATURE OF TREATING PHYSICIAN: _____ DATE: _____

CONTACT PHONE/EMAIL: _____

| HUMAN RESOURCES ONLY |

Department Contact: _____

Department Confirmation Date: _____

Part-Time schedule can be accommodated? ☐ Yes ☐ No

Department can accommodate restrictions? ☐ Yes ☐ No

Date Employee returned to work: _____

Human Resources Department
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