

**Fitness For Duty Status & Certification Form**  
**St. Olaf College**

Scan/Email: [grant2@stolaf.edu](mailto:grant2@stolaf.edu) | Fax: 507-786-3960

Employee Name: \_\_\_\_\_ Position Title: \_\_\_\_\_

**NOTICE TO EMPLOYEE**

In connection with the Family Medical Leave Act (FMLA) leave requested for your own serious health condition and the FMLA Designation Notice provided by St. Olaf College, you are required to provide this completed Fitness For Duty Certification Form:

- On an intermittent basis (maximum once every 30 days) \_\_\_\_\_
- Prior to your returning to work on or approximately \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

You are responsible for having your physician evaluate your ability to perform the essential job functions contained within your job description and certify your fitness for duty by completing all items and signing below. You will not be reimbursed for any time, travel or expenses related to obtaining fitness for duty certification. You must return this completed Fitness For Duty Status & Certification Form to the Human Resource as requested or the reinstatement of your position may be delayed or denied under the FMLA. Please note that additional clarification and/or information may need to be obtained from your doctor prior to you being partially/fully reinstated.

---

**TO BE COMPLETED BY PHYSICIAN ONLY:** (Please refer to the attached job description.)

Physician Name (Print): \_\_\_\_\_

Clinic/Hospital Name: \_\_\_\_\_

Direct Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

1. Is the employee able to resume work?  Yes  No
2. On what date is the employee able to safely Return To Work (RTW)? \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_
3. Will employee be able to perform all essential job functions on RTW date?  Yes  No
4. Are there any essential job functions unable to be performed on RTW date?  Yes  No

4a. If yes, please specify:

4b. Anticipated date employee can be restored to full duty? \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

5. Are there any other restrictions/instructions the employer should be aware of?  Yes  No
- 5a. If yes, please specify:

5b. Anticipated date when all restrictions can be removed? \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**Physician Acknowledgement**

I certify that I have examined the employee named above and declare that the statements made on this Fitness For Duty Status & Certification Form are true and accurate. I agree to obtain the necessary approval from the employee to provide St. Olaf the information contained on this Fitness For Duty Status & Certification Form and any further items needed for this certification.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date