Creighton
UNIVERSITY

Please return a copy of this form to the Human Resources Department via mail or fax to (402) 280-3113

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