Fit For Duty

COMPLETED BY EMPLOYEE

Employee: _____

Department/Location: _____

Status: Full time _____Part time_____ On leave since _____

You have my permission to contact the health care provider indicated on this form for purposes of certification and authentication.

Employee Signature: _____Date: _____

COMPLETED BY THE HEALTH CARE PROVIDER

Employee: _____is under my care. Upon review of the employee's job description, I have determined that he/she:

- ❑ Is released to return to work without restrictions on _____.
- ❑ Is unable to return to work at this time because _____.
- ❑ May return to work after _____ weeks or next medical evaluation on _____.
- ❑ Is scheduled for surgery on _____ and the patient may return to work after _____ weeks or next medical evaluation on _____ .

Additional comments, if any: _____

Name of health care provider: _____

Address: _____ Telephone: _____

Physician's Signature: _____ Date: _____

The School District of Okeechobee County recognizes the confidentiality of medical records under compliance with H.I.P.A.A.

***** Return this completed form to the Human Resources Department *****

Fax # (863) 462-5013
School District of Okeechobee County
700 SW 2nd Avenue
Okeechobee, FL 34974