Fitness - For-Duty Certification

(to be completed by employee's health care provider)

EMPLOYEE'S NAME:

EMPLOYEE'S UNIVERSITY _____

_____

☐ Employee may return to work on: _____/ _____/ _____ until (estimate) date:

_____/ _____/ _____ with the following restrictions (and /or limitations):

_____

☐ Employee may return to work on: _____/ _____/ _____ with out restrictions.

I certify that the employee named above may return to work on the above date. This certification relates only to the particular health condition that caused the leave.

Signature of Health Care Provider: _____

Date: _____

Type of Practice: _____

Address: _____

Telephone Number: _____

PLEASE RETURN THIS CERTIFICATION TO FAS HR:

fas.hr@nyu.edu