Seventh-day Adventist Church

Upper Columbia Conference
Inland Northwest Resource Center

www.uccsda.org

"FITNESS-FOR-DUTY CERTIFICATE"

FAMILY AND MEDICAL LEAVE ACT OF 1993 – "FLMA"

Employer Name: Upper Columbia Conference

Contact Information: Human Resources/Benefits
3715 S Grove Road
Spokane, WA 99224
Phone: (509) 242-0478 Fax: (509) 242-1478

A physician "fitness-for-duty certificate" is required before the employee reports for duty after an FMLA medical absence and must clearly indicate any limited duty as a return to work condition and applicable dates. Your responses should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please limit your responses to the condition for which the employee is seeking leave.

_____ (Patient Name) has been under my care and on leave under the Family Medical Leave Act ("FMLA") because of a serious health condition that rendered the employee unable to perform the essential functions of his/her position. Currently, the employee is scheduled to return to work on _____. However, before the employee will be permitted to return to work it is my understanding that the employee must submit a medical certification that they are able to return to work. This certification relates only to the particular health condition that caused the employee's need for medical leave.

I hereby certify that the employee is now able to perform the essential functions of his/her position and may return to employment in that or a similar position.

If there are limitations that prevent the employee from returning to work full-duty at this time, I have indicated those restrictions in detail below.

- ☐ Full-duty release
- ☐ Limited duty release through _____ (indicate restriction(s) below)
- ☐ Lifting restriction of _____ lbs
- ☐ Working no more than _____ hours per day, _____ days per week
- ☐ Standing or walking no more than _____ minutes at a time
- ☐ No driving or using heavy machinery
- ☐ No performing activities requiring concentration or significant decision making
- ☐ Other (please list below in detail)

_____

_____

_____ _____
Signature of Health Care Provider Date

_____ _____
Type of practice/medical specialty Phone Number