YALE NEW HAVEN HEALTH

PERSONAL AND CONFIDENTIAL

TO: Health Care Provider

FROM: House Staff Office T-209

RE: Fitness for Duty Certification under FMLA for _____
(Employee's Name)

In order to return to work from Family/Medical Leave, the employee must submit this completed form to the Hospital prior to the actual return to work date; if no form is received by that date, his/her employment will be terminated.

Based on your review of this employee's job responsibilities and your understanding of this employee's health condition, please state below that this employee: (Please check all that apply)

_____ Is able to resume his/her job duties.

_____ Is unable to resume his/her job duties.

_____ May be able to resume his/her job duties with the following accommodation:

_____

_____

_____ May be able to work, but only at a different position that allows for the following restrictions:

_____

_____

_____ _____

Health Care Provider's Signature Date

_____

Print Name

Please return this completed form directly to the employee