The University of Texas Health Science Center at Houston (UTHSC-H)

Certification of Fitness for Duty
With Job Description Attachment

Employee Information. (To be completed by employee)

Employee name: _____

Relationship to employee *(if patient is someone other than employee)*: _____

Employee's date of birth: _____ EMPLID:_____

Employee's home address: _____

City/State/Zip _____

Employee signature/date: _____

Health Care Provider Information. (To be completed by health care provider)

Name: _____ Telephone:_____

Address: _____

City/State/Zip:_____

Type of practice or field of specialization: _____

Date licensed: _____ State(s): _____

Information relating to serious health condition.

1. Date patient was last examined:
2. I have reviewed my patient's job description and I believe the patient is **able / unable** to perform those duties at this time.
3. The following restrictions or precautions may be necessary for the patient upon returning to work. (If no restrictions apply please state so):

4. It is my opinion that this patient **should / should not** return to work at this time.
5. This patient will be able to return to work on (date)_____ .

I certify that the above representations accurately reflect my informed medical opinion with regard to this patient and the patient's ability to return to work at this time.

Physician Signature/Date:_____