

ATTACHMENT XIV  
**FITNESS-FOR-DUTY CERTIFICATION**  
**FMLA LEAVE**  
(to be submitted prior to reinstatement)

Employee's Name: \_\_\_\_\_ Position: \_\_\_\_\_

Building: \_\_\_\_\_

Employee's serious health condition which caused him/her to take FMLA leave:

\_\_\_\_\_  
\_\_\_\_\_

Date FMLA Leave commenced: \_\_\_\_\_

Date FMLA Leave is set to end: \_\_\_\_\_

Name of Treating Health Care Provider: \_\_\_\_\_

Medical Practice (Field of Specialization, if any): \_\_\_\_\_

***THE EMPLOYEE IS ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF HIS/HER JOB,  
WITH OR WITHOUT A REASONABLE ACCOMMODATION.***

**Y      N**

Any restrictions or accommodations necessary to allow the Employee to return to work:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Health Care Provider's Signature

\_\_\_\_\_  
Date

THIS IS A CONFIDENTIAL RECORD AND IT SHALL BE MAINTAINED AS SUCH  
AS REQUIRED BY THE AMERICANS WITH DISABILITIES ACT.