



COMMONWEALTH OF MASSACHUSETTS

FITNESS-FOR-DUTY CERTIFICATION

DIRECTIONS TO EMPLOYER:

- 1. Please attach the employee's job description to this form, including the essential functions of his/her position.
2. Give this form and the job description to the employee to obtain the requisite medical certification.

DIRECTIONS TO EMPLOYEE:

- 1. You may use this form to obtain a certification from your health care provider certifying that you are able to return to work.
2. Please have your physician fill out this form.
3. Please return this form to your supervisor before you return to work.

TO BE COMPLETED BY EMPLOYEE: (please print or type)

- 1. Name:
2. School:
3. Date condition began
4. Date condition ended (or is expected to end)
5. Date planned for return to work

I understand that if I do not provide a requested fitness-for-duty certification to return to work, my employer may delay restoration until I submit the certification.

Employee's Signature \_\_\_\_\_ Date: \_\_\_\_\_

TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER: (please print or type)

- 7. I certify that I have read the job description enclosed with this form and that the above-named employee is physically fit to meet the physical/mental requirements listed in the description with or without (please circle one) reasonable accommodation. If accommodation is required, please list specific limitations to activity in the remarks section, below.

Signature of Health Care Provider \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

Address \_\_\_\_\_

Area of Practice/Specialty (if any): \_\_\_\_\_

Remarks:

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

Please return this form to: Mickey Fredericks - Human Resources
Westport Community Schools
14 Main Road
Westport, MA 02790

FOR OFFICE USE ONLY
Confirm Return Date: \_\_\_\_\_
Notified Payroll On: \_\_\_\_\_
Initials: \_\_\_\_\_