



HUNTSVILLE

CITY OF HUNTSVILLE  
RETURN TO WORK  
FITNESS FOR DUTY MEDICAL CERTIFICATION

**EMPLOYEE: Please complete this section of the fitness for duty medical certification.**

You are required to have this fitness for duty medical certification form completed by your health care provider. Once completed by your health care provider, you must submit the completed certification form to your department. The department should submit a copy of the completed certification form to Human Resources.

**Employee Name: (Please Print)** \_\_\_\_\_

**Job Title:** \_\_\_\_\_

**Department:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Division:** \_\_\_\_\_

**Date Condition Began:** \_\_\_\_\_

**Work Schedule (hours/days):** \_\_\_\_\_

*I authorize the health care provider identified below to provide the information requested on this form for the purposes of determining my fitness for duty and a City of Huntsville Human Resources professional to contact my health care provider to authenticate and/or clarify information, if needed. I understand that if I do not agree to this authorization, my return to work may be delayed or denied.*

**Employee's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**HEALTH CARE PROVIDER: Please complete the following section of the fitness for duty medical certification.**  
Please review the employee's job description and work schedule and complete the following:

I have reviewed the essential functions of the above named employee's position. \_\_\_\_ Yes \_\_\_\_ No

Effective \_\_\_\_\_ (date), the employee is certified to resume work duties as follows:

- Full-time duties, no restrictions on essential duties
- Full-time duties, with the following restrictions on essential duties

**(please list specifics including duration)**

\_\_\_\_\_

- Part-time duties, no restrictions on essential duties

Recommended number of hours/days of work per week: \_\_\_\_\_

- Part-time duties, with the following restrictions on essential duties

Recommended number of hours/days of work per week: \_\_\_\_\_

**(please list specifics including duration)**

\_\_\_\_\_

**Additional Comments:**

\_\_\_\_\_

**GINA Notification to Health Care Providers:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information on employees or their family members. In order to comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. 'Genetic information', as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**Health Care Provider Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Type of Practice/Specialty:** \_\_\_\_\_