



DOUGHERTY COUNTY SCHOOL SYSTEM
Benefits Department

FITNESS - FOR - DUTY REPORT

| EMPLOYEE INFORMATION | | | |
|----------------------|--|---------------------------|--|
| Name: | | | |
| Date: | | Social Security #: | |
| Job Title | | | |

| CERTIFICATION | |
|---|-------------|
| <p>This is to attest that the individual named above is certified to be "fit for duty" and is able to return to work on _____.</p> <p align="center">(Date)</p> <p align="center">_____ No Restrictions: _____ Restrictions:</p> <p>List restrictions if any: _____</p> <p>If restrictions are indicated above, give a date when normal job duties may resume without restrictions _____</p> <p>Or, give the date of a follow up appointment for re-evaluation of employee's ability to return to work _____</p> | |
| X | |
| Signature of Physician or Health Care Provider | Date |

| Health Care Provider Information | |
|----------------------------------|--|
| Physician | |
| Business Name | |
| Address and Phone # | |

This form must be completed by physician and returned to the leave office before returning to work.
A copy should also be given to employee's supervisor prior to returning to work.