



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

Employee Name: \_\_\_\_\_

Employee Address: \_\_\_\_\_ City/State/Zip Code: \_\_\_\_\_

From: *Darryl Bowie, Director, Human Resources*

Please take this Fitness for Duty Certification to your healthcare provider for completion. Rockdale County will use this Fitness for Duty Certification to determine if you are able to perform the essential duties of your work.

The physician performing your exam should return the completed Fitness for Duty Certification to your Human Resources Department. This form can be email to [hr.benefits@rockdalecounty.org](mailto:hr.benefits@rockdalecounty.org) or faxed to us at (770)918-6438.

**FITNESS FOR DUTY CERTIFICATION**

**Health Care Provider Completes this Section:** Instructions: Please complete all sections in order for the County to determine if the employee is able to return to duty. **The employee's position description or a list of essential duties is attached to this form.**

yes  no The employee is able to return to work full-time without restrictions.

If yes, list the effective date \_\_\_\_\_.

If no, complete the following:

The employee will be able to return to work with no limitation on (date) \_\_\_\_\_

I certify that from (date) \_\_\_\_\_ to (date) \_\_\_\_\_ the above named employee will be:

unable to perform the physical requirements of their work or

is medically incapacitated:  totally  \*\*partially

\*\*If partially medically incapacitated, complete the following:

Number of hours per day employee is able to work \_\_\_\_\_

Number of days per week employee is able to work \_\_\_\_\_

List any restrictions on the employee's work:

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

\_\_\_\_\_  
**PRINTED** Name of Health Care Provider

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Signature – Health Care Provider

\_\_\_\_\_  
Date

\*\*\*Please return the completed form to the employee/patient\*\*\*