CANYONS SCHOOL DISTRICT

Human Resources

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Fitness for Duty Certification

(This section to be completed by the employee's Health Care Provider)

Patient's Full Name: _____

Start Date of Leave: _____

I have examined the above named patient and certify that he/she is fully able to perform all essential functions of his/her job description effective ____/____/____.

_____ _____
Health Care Provider's Signature Date

_____
Name of Health Care Provider (Please Print)

DO NOT SEPARATE

Notice of Intention to Return from a Medical Leave

(This section to be completed by the Employee)

I have been released to return to my regular duties effective ____/____/____.

I will be reporting to work at that beginning of my shift effective ____/____/____.

My return to work date will be delayed until ____/____/____ for the following reason:

_____

_____ _____
Employee's Signature Date