THE LINCOLN UNIVERSITY
1854

Office of Human Resources

Phone: 484-365-8059
Fax: 484-365-8060

The Lincoln University

Fitness for Duty Certification/Intent to Return to Work

Section 1: To be completed by EMPLOYEE:

Employee Name (please print)_____

Department/Office_____

Contact Information:

Phone:_____ Email:_____

If leave was for a continuous block of time and my health care provider has released me to return to work:

(Check one):
I intend to return to work as scheduled. ( )
I do not intend to return to work and I am resigning my employment with Lincoln University. ( )

(Check one):
I ( ) authorize ( ) do not authorize – The healthcare provider identified below to provide the information requested on this form for the purposes of determining my fitness for duty and for a designated Lincoln University Human Resources Representative to contact the health care provider to authenticate and/or clarify the 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:_____

An employee who fraudulently obtains Medical, FMLA and/or Workers Compensation leave will be subject to disciplinary action, up to and including termination.

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Section 2: To be completed by HEALTHCARE PROVIDER:

Please complete all sections in order for the university 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 limitations 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 _____

Please indicate restrictions, if any, below for:

Standing	_____	Sitting	_____	Walking	_____
Lifting	_____	Carrying	_____	Use of hands	_____

Any other restrictions/Additional Comments_____

_____

HEALTH CARE PROVIDER INFORMATION:
Name of Health Care Provider (please print)_____

Type of Practice_____Phone_____

Address:_____

_____ _____
Signature –Health Care Provider Date

Please return the completed form to the employee/patient.

Attached: position description/description of essential duties