Fitness-For-Duty Certification
(To be completed by employee's health care provider)

Employee Name: ____

Employee ID Number: ____

☐ Employee can return to work on: ____/____/____ until date: ____/____/____ with the following restrictions (and/or limitations):
____
____
____.

☐ Employee can return to work on: ____/____/____ without restrictions.

I certify that the employee named above may return to work on the above date.
(This certification relates only to the particular health condition that caused the leave.)

Signature of Health Care Provider & Date: ____

Type of Practice: ____

Address: ____

Telephone Number: (_____)____

Please return this certification to:

Human Resources
1250 Homer Road
Winona, MN 55987
Fax: (507) 453-1429