RESEARCH FOUNDATION CUNY

**RESEARCH FOUNDATION**
of The City University of New York
230 West 41st Street
New York, NY 10036-7207

# FITNESS FOR DUTY CERTIFICATION

An employee on FMLA or Non-FMLA Medical Leave of Absence (LOA) because of his / her own serious medical condition must present this certification to the Department of Human Resources prior to or on the day he / she returns to work.

Employees may not work without this certification. If you are on unpaid leave, Human Resources will place you back on the payroll only upon receipt of this form.

Supervisors must not permit employees to return to work without this certification, and must forward this form to the Leaves Management Administrator in the Department of Human Resources via fax to 212-417-6368 or by email to David_Nabatov@rfcuny.org.

**Patient / Employee Information**

Name _____ Job Title _____

**Health Care Provider**

The employee noted above began a period of medical care leave for their own serious health condition on _____
Date

As a condition to return to work, the employee must have a health care provider certify that the employee is medically fit to resume their job duties.

Date employee may return to work _____

Is the employee able to return to work without posing a significant risk or substantial harm to themselves or others? ☐ Yes ☐ No

☐ Employee may return to work with full, unrestricted duty.

☐ Employee may return to work with modified duty. Explain _____

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If the employee is being released to modified duty, please complete the following

Estimated date when employee will be able to return to full unrestricted duty _____

Date of next medical evaluation of the employee _____

**Health Care Provider Certification**

I certify that the above facts are true and correct.

Physician's Stamp

| | |
|---|---|
| Signature | Date |
| Print Name | Phone Number |
| Type of Practice | Address |
| License Number | City State Zip |

**For Department of Human Resources**

Received by (This form must be signed by the Leaves Management Administrator of Human Resources or Designee)

Signature _____ Print Name _____ Date _____