

TUNKHANNOCK AREA SCHOOL DISTRICT

FITNESS FOR DUTY CERTIFICATION

EMPLOYEE: \_\_\_\_\_

DEPARTMENT/LOCATION: \_\_\_\_\_

STATUS: \_\_\_\_\_ FULL TIME \_\_\_\_\_ PART TIME ON LEAVE SINCE: \_\_\_\_\_  
(Date)

You have my permission to contact the healthcare provider indicated on this certification for purposes of authentication and clarification related to this serious health condition, if necessary.

Signed \_\_\_\_\_ Date \_\_\_\_\_

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*(Information below to be completed by healthcare provider)*

Effective as of \_\_\_\_\_, the above-named employee is:  
(Date)

- Released to work without restrictions; or
- Able to perform all essential duties; or
- Released to work with restrictions (please describe restrictions below): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of healthcare provider: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Type of practice/specialty: \_\_\_\_\_  
\_\_\_\_\_

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