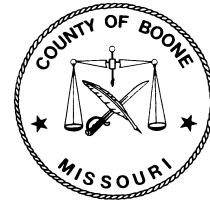


# BOONE COUNTY GOVERNMENT

801 E. WALNUT  
COLUMBIA, MO 65201



## FMLA RETURN TO WORK

### FITNESS FOR DUTY MEDICAL CERTIFICATION

**EMPLOYEE:** PLEASE FILL OUT THE TOP PORTION, AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER.  
THIS CERTIFICATION MUST BE PROVIDED TO YOUR DEPARTMENT PRIOR TO YOUR RETURN TO WORK.

Employee:

Employee's Department:

Department Address:

Department Contact:

Telephone Number:

Fax Number:

**HEALTH CARE PROVIDER:** PLEASE COMPLETE THE FOLLOWING AND RETURN DIRECTLY TO THE DEPARTMENT LISTED ABOVE PRIOR TO THE RETURN TO WORK DATE.

Please review the attached job description. Is the employee able to perform all the functions of his or her job?

Yes     No     Yes, with restrictions.

Please list any restrictions or functional limitations which the department should consider:

Are the restrictions:     Permanent     Temporary, until (date):

Comments

Employee is released to return to work effective (date):

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

Name of Health Care Provider:

Address:

Telephone Number: