Western Oregon UNIVERSITY

FITNESS FOR DUTY MEDICAL VERIFICATION (RETURNING FROM FMLA)

PART I – TO BE COMPLETED BY EMPLOYEE

This form must be submitted on or before the day you return to work.

Employee: _____ V#_____

Title/Department: _____

Date returning to work: _____

PART II – TO BE COMPLETED BY PHYSICIAN

The purpose of this form is to certify that the employee is fit to return to work and do the essential functions as designated on the attached position description.

Is the employee able to perform the essential functions of their position that are described in the attached position description? Yes [ ] or No [ ]

If No, can the employee return to a modified work plan? (Please describe restrictions needed.)

_____

_____

_____

_____

_____

Estimated return to **full-duty**: _____

Next appointment date: _____

Physician's Name: _____

_____ _____

Physician's Signature Date

Copies: Employee's Family Leave file, Department

Office of Human Resources
345 N. Monmouth Ave., Monmouth, OR 97361; Phone: 503.838.8490; Fax: 503.838.8144; wou.edu.hr