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# FITNESS FOR DUTY CERTIFICATION

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## Halifax County Human Resources

Employee Name: \_\_\_\_\_

Department: \_\_\_\_\_

Status: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ On Leave Since: \_\_\_\_\_

**(Information below to be completed by health care provider)**

Effective as of \_\_\_\_\_, the above named employee is hereby certified as fit to resume work duties as follows:

- Full time duties, with no restrictions
- Full time duties, with the following restrictions (conditions and duration):

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- Intermittent duties, with the following restrictions (conditions and duration):

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Additional comments, if any: \_\_\_\_\_

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Name of Health Care Provider: \_\_\_\_\_

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

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_