Community Unit School District 303

Fitness for Duty Certificate

Employee Name: _____Position:_____
(Please Print)

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***To be completed by your Physician - Please check the appropriate box below*:**

☐ **Employee may return to work with no restrictions on _____**
Date

☐ **Employee may return to work with the following restrictions on _____**
Date

***Please list specific restrictions*: _____**

_____

Employee must receive prior authorization from Human Resources before returning to work with restrictions

☐ **Employee may not return to work - Anticipated return to work: _____**
Date

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_____ _____
Physician's Signature **Date**

_____
Physician's Name (Please Print)

_____
Physician's Address and Phone # or attach Physician's Business Card

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RETURN TO:
Community Unit School District 303
Attn: Human Resources Dept.
201 South 7th Street
St. Charles, IL 60174
HR FAX# 331-228-2018

Oct 2015