Fitness-For-Duty Certification
(To be completed by employee's health care provider)

Employee Name:

Employee ID Number:

☐ Employee can return to work on: ____/____/____ until date: ____/____/____ with the following restrictions (and/or limitations):
_____
_____
_____.

☐ Employee can return to work on: ____/____/____ without restrictions.

I certify that the employee named above may return to work on the above date.
(This certification relates only to the particular health condition that caused the leave.)

Signature of Health Care Provider & Date: _____

Type of Practice: _____

Address: _____

Telephone Number: (_____)_____

Please return this certification to:
Human Resources
1250 Homer Rd.
Winona, MN 55987
Fax: (507) 453-1429
Phone: (507) 453-2676