City of Oak Harbor
865 SE Barrington, Drive, Oak Harbor, WA 98239

Fitness for Duty Certification

PART A: TO BE COMPLETED BY EMPLOYEE
(PART B TO BE COMPLETED BY ATTENDING PHYSICIAN)

Employee: _____ Date of Birth: _____

Job Title: _____ Department: _____

Employee Acknowledgment:
The Human Resource Department has my permission to contact my health care provider indicated on this certification for purposes of clarification and authentication.

Employee Signature:_____ Date:_____

Employee Job Description Attached

PART B – TO BE COMPLETED BY ATTENDING PHYSICIAN

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

☐ **Full-time duties, no restrictions, return to work.**

☐ **Unable to resume full-time duties, has the following restrictions (conditions and duration):**

☐ **Part-time duties, no restrictions, return to work.**

☐ **Unable to resume part-time duties, has the following restrictions (conditions and duration):**

☐ **Intermittent duties, no restrictions, return to work.**

Will any medication(s) prescribed impair the employee's job performance, including the ability to drive and operate equipment? ☐ **Yes** ☐ **No**

Describe:

Name of attending Physician:_____

Address and Phone:_____

Physician Signature:_____ **Date:**_____