FITNESS FOR DUTY STATEMENT
(Family and Medical Leave Act) FMLA Form H

PART A: TO BE COMPLETED BY EMPLOYER

ATTENTION HEALTH CARE PROVIDER:

Employer: Town of Greenfield
Address: Human Resources Dept, Town Hall
14 Court Square
Greenfield, MA 01301

Date: _____ Employee: _____

Department: _____ Position: _____

The above named employee has been absent from his/her regular duties as a result of an injury/illness on _____ due to a □ job related □ non-job related incident.

The nature of the injury or illness as the Town understands it is:

_____

_____

This employee has been directed to obtain a statement of medical disposition from you as:

_____ Treating Health Care Provider _____ Town Designated Health Care Provider

Note: The employee in question will not be able to return to his/her regular duties without completion of this statement. A job description for the employee's position is attached to assist you in your determination. Thank you for your assistance.

PART B: TO BE COMPLETED BY EMPLOYEE

I, _____, consent to the release of all medical information as it relates to my physical ability to perform my job to the Town's Human Resources Department listed above.

_____ _____
Employee's Signature Date

HEALTH CARE PROVIDER'S STATEMENT

Diagnosis

I certify that I have reviewed the attached job description and physical requirements and, in my opinion, this individual:

____ Is able to perform all the duties as of _____, fully without restriction.
(date)

____ Is able to perform all the duties as of _____, with the following restrictions:
(date)

I further recommend the following medical care or treatment:

_____

Date of next appointment (if applicable):

_____

____ Is totally unable to perform the duties as of _____.

Prognosis and Recommendation

This section must be completed if the employee's abilities are partially or totally restricted at this time.

In my medical opinion, I anticipate this condition to last for a period of _____, with a projected date for a complete recovery of _____.

I further recommend the following medical care or treatment:

_____

_____

Date of next appointment (if applicable): _____

Name of Health Care Provider (Please Print): _____

Address: _____

_____ _____
Signature of Health Care Provider Date