TOWN OF GREENFIELD
WORKERS COMPENSATION
EMPLOYEE FITNESS FOR DUTY CERTIFICATION

Employee: _____ Department: _____

Status: Full-time Part-time On leave since: _____

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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 No restrictions

_____ Full time duties with the following restrictions:

_____ Part time duties No restrictions

_____ Part time duties with the following restrictions:

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

Print Name of Health Care Provider: _____

Address: _____ Telephone: _____

Practice Speciality: _____

Signature: _____ Date: _____