Jordan School District
Department of Human Resources
7387 South Campus View Drive • West Jordan 84084
Phone (801) 567-8150 • Fax (801) 567-8056

Fitness for Duty Certification

(This section to be completed by the employee's Health care provider)

Name of Patient: ____

Start date of Leave: ___/___/___

I have examined the above named patient and certify that he/she is fully able to perform all essential functions of his/her job description effective ___/___/___.

______________________________ ______________________
Health Care Provider's Signature Date

____
Name of Health Care Provider (Please print)

(DO NOT SEPARATE)

Notice of Intention to Return from a Medical Leave

(This section be completed by the Employee)

I have been released to return to my regular duties effective ___/___/___.

- ☐ I will be reporting to work at that beginning of my shift effective ___/___/___.
- ☐ My return to work date will be delayed until ___/___/___ for the following reason:

____

______________________________ ______________________
Employee's Signature Date

____
Employee's Name (Please Print)