

# WINONA

STATE UNIVERSITY  
*Human Resources*

## **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:**

WSU-Human Resources

PO Box 5838

Winona, MN 55987

Fax: (507) 457-2269