CITY OF HOUSTON - FAMILY AND MEDICAL LEAVE
FITNESS FOR DUTY CERTIFICATION

_____ _____/_____/_____ _____
Employee Name (first, mi, last) Social Security No. Employee No.

_____
Employee Address City State Zip Code

_____
Job Title

INSTRUCTIONS TO HEALTH CARE PROVIDER

The above individual desires to return to work after a Family and Medical Leave for his/her own serious health condition. Please complete and sign this form.

Is the employee ready to return to work duties?

CHECK ONE

☐ Regular duty with no restrictions _____/_____/_____
Return to work date

☐ Duty with the following restrictions

_____/_____/_____ until _____/_____/_____
Return to work date Date restrictions end

_____

_____

☐ No duty; the employee is not yet released to return to work.

_____ _____/_____/_____
Health Care Provider's Signature Date

_____
Health Care Provider's Name (please print)

_____
Health Care Provider's Area of Specialty

_____
Address City State Zip Code

(_____)_____-_____ (_____)_____-_____
Telephone Number Fax Number

Form J