Kentucky Community & Technical College System

Fitness for Duty Certification

Employee Name: ____

Employing College: ____

Supervisor Name:

Status: ☐ Full Time ☐ Part Time On Leave Since: ____________________

You have my permission to contact the health care provider indicated on this certification for purposes of certification and authentication.

____ ____________________

Employee Signature Date

(Information below 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 (conditions and duration):

____

____

☐ Part time duties, no restrictions

☐ Part time duties, with the following restrictions (conditions and duration):

____

____

☐ Intermittent, with the following restrictions (conditions and duration):

____

____

☐ Are interpersonal relations affected because of a condition? (e.g., ability to give or take supervision, meet deadlines, etc.) ☐ Yes ☐ No

____

____

Kentucky Community & Technical College System

Additional comments, if any: ____

____

Name of Health Care Provider: ____

Address: ____

Type of Practice/Specialty: ____

____ ____________________

Health Care Provider Signature Date