EUGENE BURGER MANAGEMENT CORPORATION

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Rohnert Park, CA 94928

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Certification of Fitness for Duty

To be completed by a healthcare provider prior to returning to work. Please attach any additional doctor's notes or forms.

Employee Information

Employee Name: _____

Job Title: _____

Job Description Attached: ☐ Yes ☐ No

Health Care Provider Certification

Based on my examination of the employee listed above, and having reviewed the job description if indicated above that it is attached, it is my informed professional opinion that the employee:

☐ Is able to return to work without restrictions on _____ (date).

☐ Is not able to return to work at this time.

☐ Is able to return to work with the following restrictions on _____ (date):

_____

_____

_____

_____

_____

_____

_____

Health Care Provider Information

Name: _____ Phone: _____

Type of Practice: _____

I certify that this accurately reflects my informed professional opinion regarding this individual's ability to return to work and perform job tasks as indicated at this time.

Provider Signature: _____ Date: _____