MFRM FAMILY OF BRANDS

Certification of Fitness for Duty

Please note that this Associate will not be permitted to return to work until this evaluation is totally completed, and is received by the Leave of Absence Administrator.

Employee Information

Associate Name: _____ Date of Birth: _____

Job Title _____ Department: _____

Name of Leave of Absence Contact and Phone Number: Kristin Hilbert 713-328-3577

Administrator Fax Number: 888-882-5016

Provider Information (To be filled out by Health Care Provider)

Provider Name: _____

Provider Phone: _____ Date Licensed: _____ State: _____

Degree/Type of Practice/Area of Specialization: _____

Address: _____

Date of examination: _____

I have reviewed the Patient's job duties (see attached) and I believe the patient is:

☐ **Able to return to work, at this time.**

☐ **Unable to return to work, at this time.**

The individual will be able to return to work on (date) _____.

Please list any restrictions:

_____

_____

_____

I Certify that this accurately reflects my informed, professional opinion regarding this individual's ability to return to work and perform his/her job duties as indicated, at this time.

Provider Signature: _____ Date:_____