



**FMLA FITNESS FOR DUTY CERTIFICATION OF
TREATING HEALTH CARE PROVIDER**

EMPLOYEE NAME: _____

Please be advised that the above-referenced FIT employee has been under my care for a serious health condition that warranted leave from work under the Family and Medical Leave Act (FMLA).

This will confirm that _____ is now fit to return to work, effective _____.

Signature of Health Care Provider
(print)

Name of Health Care Provider (please
print)

Date of Signature

_____/_____
Telephone Number and Fax Number

Street Address

City, State and Zip Code

**PLEASE RETURN FULLY COMPLETED
FORM BY eFAX TO:**

Cherese Hill-Cartagena
Office of Human Resources
Fashion Institute of Technology
eFax: (917) 456-9519