Fashion Institute of Technology
State University of New York

**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.**

_____ _____

Signature of Health Care Provider 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

Rev 05/24