Fitness for Duty Certification
Cigna Leave Solutions®

This Fitness for Duty Certification must be completed by your Health Care Provider and submitted to your employer at least two days prior to your return to work for a federal and/or state and/or a company leave.

Date Prepared:

This section to be completed by the EMPLOYEE:	
Employee Name:	**Employee ID:**
Name of Employer:	
Leave Number:	
Date Leave Began:	
Return To Work Date:	
I understand that I cannot return to work without a release from my health care provider.	
Employee's Signature:	**Date**:

This section to be completed by the Health Care Provider:	
I have examined the employee named above and certify that this person is medically able to resume working on:	
This employee can return to work: ☐ With No Restrictions ☐ With Restrictions (outline details below)	
If the employee is returning with restrictions, please state in detail the employee's restrictions and the duration of these restrictions:	
Signature of Health Care Provider:	**Date:**
Name of Health Care Provider (Please Print)	