



**FITNESS FOR DUTY CERTIFICATE**

Employees returning to work following medical leave must furnish EAB Global with a release from their health care provider. This form may be used for that purpose.

<b>Employee Information</b> (to be completed by employee)	
Patient/Employee Name:	Employee ID#:
I authorize my health care provider to provide information about my health condition to EAB Global.	
Signature: _____ Date: _____	

<b>Health Care Provider Information</b> (to be completed by Health Care Provider)
The patient named above has been released to return to work on ____ ____ ____
This release is <input type="checkbox"/> unconditional <input type="checkbox"/> conditional (note conditions below)
Restrictions and Limitations
<input type="checkbox"/> These restrictions are in effect until ____ ____ ____
<input type="checkbox"/> These restrictions are permanent
_____
_____
_____
_____

My signature below verifies that the information provided above is true and accurate.

\_\_\_\_\_

Printed Name and Degree Specialty

\_\_\_\_\_

Signature of Health Care Provider

\_\_\_\_\_  
Printed Street Address

\_\_\_\_\_|\_\_\_\_\_  
Telephone Number | Fax Number

\_\_\_\_\_  
Printed City, State, ZIP

\_\_\_\_\_  
Date

**This form must be returned to the EAB Benefits Team BEFORE YOU RETURN TO WORK**

**Email: [Benefits@eab.com](mailto:Benefits@eab.com)**

**Fax: 202-516-8289**