FORM 620-16
FITNESS –FOR-DUTY MEDICAL CERTIFICATION

This form should be typed or printed and delivered or mailed to:
Region One School District
c/o Business Office
246 Warren Turnpike Road
Falls Village, CT 06031
Attn: Business Office

PART I: TO BE COMPLETED BY THE EMPLOYEE			
Name of Employee:		Employee's Position:	
Date Leave Commenced:		Date Employee Can Return to Work:	
Employee's Signature		Date	

PART II: TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

I certify that on _____ (date) _____ (name of employee), is able to resume performing the functions of his/her position with or without reasonable accommodations.

Signature of Health Care Provider Date

Health Care Providers Name, Address and Telephone No.