Human Resources Certification of Fitness For Duty

Work/Life and Employee Assistance Program

Revised 6/27/16

Please note that this employee **will not be permitted to return to work** until this completed evaluation form is received by The University of Texas at Austin.

Employee information

Employee name | Job title | Date of birth

Department | Name of Department Contact

This employee has been referred to you for an evaluation and confirmation of fitness for duty based on the following observations on (date) _____

Provider information — to be completed by healthcare provider

Provider name | Provider phone

Degree | Type of practice/area of specialization | Date licensed | State

Address

Date of examination

I have reviewed this patient's job duties **(see attached)** and I believe the patient is ☐ able ☐ unable to perform those duties at this time.

This individual will be able to return to work on (date) _____

Other requested information:

I certify that this accurately reflects my informed professional opinion regarding this individual's ability to return to work and perform job tasks as indicated at this time.

Provider signature | Date

Please fax this completed form to UT Work/Life Services & EAP
Fax **512-475-8558**

HealthPoint EAP · Mail Code A9200 · 101 E 27th St STOP A9200 · Austin, TX 78712
phone 512-471-3366 · fax 512-475-8558 · hr.utexas.edu/eap/