Policy Exhibit #2 DKC

_____District
Certificate of
Fitness for Duty

_____ (employee's name) is a patient of mine. It is my understanding that _____'s (employee's name) employment with the _____ School District requires him/her to be able to perform the following activities with accompanying weekly time requirements:

_____

_____

_____

_____

_____

_____

_____

On _____,(date) I personally evaluated _____ (employee's name). I certify that based upon my education and clinical expertise _____ (employee's name) is fit to return to his/her employment with the _____ District.

_____
Signature

_____
Title