GROUP BENEFIT
SOLUTIONS

Fitness for Duty Certification
NYL GBS Leave Solutions

Please refer to your NYL GBS Leave Solutions letters for further instructions on when and who this form should be returned to at your employer.

Date Prepared: ____________________

This section to be completed by the EMPLOYEE:	
Employee Name: ________________________	**Employee ID**: ____________________
Name of Employer: ________________________	
Notification #: ____________________	
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): __________________________________	

Document ID: 158210140 Notification #: _____________ Absence #: _____________