NEW YORK LIFE 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 Number: _____	
Date Leave Began: _____	Return to Work Date: _____
I understand that I cannot return to work without a release from my health care provider.	
Employee 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 #: _____