Unified Government Human Resources Guide

Effective: 04-01-05

FITNESS FOR DUTY CERTIFICATION

Note: Do not complete this form until the patient is ready to return to work.

Employee Name _____ Date of Injury/Illness_____

RETURN TO WORK DATE: _____

WORK STATUS: ☐ Return to FULL duty

☐ Return to MODIFIED duty with RESTRICTIONS noted below:

- ☐ Employee taking medication which may cause drowsiness
- ☐ Protect wound. Keep wound clean and dry.
- ☐ Right-hand work only ☐ Left-hand work only
- ☐ No overhead work or may reach to shoulder level only
- ☐ No pulling or crawling
- ☐ Restricted lifting:
  - Circle maximum weight in pounds: 10 20 30 40 50
  - Circle maximum times per hour: 0-2 2-6 6-10 10+
- ☐ Restricted bending and stooping
- ☐ Sitting job only
- ☐ No work requiring repetitive bending of _____
- ☐ No operation of motor vehicle or heavy equipment
- ☐ No work around high speed or moving machinery
- ☐ No climbing stairs or ladders
- ☐ No repetitive shoveling
- ☐ Other RESTRICTIONS: _____
- ☐ Estimated duration of limitations _____ Days _____ Unknown

FOLLOW-UP CARE:

- ☐ Next physician's appointment
- ☐ Physical therapy _____ times per week

COMMENTS: _____

_____

Attached is a description of the essential job functions of this patient. Within a degree of medical certainty, can the employee perform these tasks?

Please Comment: _____

_____

_____ _____ _____

Physician's Name (Please type of print.) Physician's signature Date