Fitness for Duty Certificate

An employee, because of his/her own serious medical condition, must present this release to his/her supervisor prior to or on the day he/she returns to work. An employee may not work without this release.

Employee Information

Employee Name: _____ Date of Birth: _____

Job Title: _____ Department: _____

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

Provider Information – to be completed by healthcare provider

Provider Name: _____ Provider Phone: _____

Address: _____

Type of practice/area of specialization: _____

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

This individual will be able to return to work on _____.

Please indicate the status of the employee's release for duty:

☐ Full, unrestricted duty

☐ Modified duty

☐ Not released for any type of duty

If you are releasing the employee to modified duty, please complete the following:

Estimated date that employee will be able to return to full, unrestricted duty: _____

Date of your next medical evaluation of the employee: _____

Employee Name: _____

Indicate the exact work restrictions which apply to the employee currently on the chart below:
(Complete this section if the employee is being released to modified duty.)

PHYSICAL EXAMINATIONS	FULL RESTRICTIONS	PARTIAL RESTRICTIONS	NO RESTRICTIONS
Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing/Carrying			
Reaching or working above shoulder			
Walking (hrs. per day)			
Standing (hrs. per day)			
Sitting (hrs. per day)			
Stooping (hrs. per day)			
Kneeling (hrs. per day)			
Repeated Bending (hrs. per day)			
Climbing (hrs. per day)			
Operating a motor vehicle (hrs. per day)			
Cognitive Health (Emotional or Psychological)			
Other:			

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:** _____