FITNESS FOR DUTY
MEDICAL CERTIFICATION

EMPLOYEE NAME _____

Employee may return to work **without** restrictions on _____ (Date)

Employee may return to work on _____(date) with the following restrictions.

RELEASE TO RETURN TO WORK WITH RESTRICTIONS

1) Length of shift: ( ) 4 hours ( ) 6 hours ( ) 8 hours ( ) over 8 hours

2) Number of shifts/week: ( ) 1-2 ( ) 3-4 ( ) 5 ( ) over 5

3) Physical restrictions:

Lifting: ____ Frequently (10 + x/hr) ____ Occasionally (1-9 x/hr) ____ Not at all
Lifting weight limit: ____ #10 ____ #20 ____ #50 ____ #100 ____ Other, please define

Pushing/Pulling: ____ Frequently (10 + x/hr) ____ Occasionally (1-9 x/hr) ____Not at all

Pushing/Pulling weight limit: ____ #10 ____ #20 ____ #50 ____ #100 ____ Other, please define

Bending/Stooping/Twisting: ___ Frequently (10+x/hr) ___ Occasionally (1-9 x/hr) ___ Not at all

Walking: ____ Over 6 hrs/shift ____ 1-6 hrs/shift ____ Not at all

Standing: ____ Over 6 hrs/shift ____ 1-6 hrs/shift ____ Not at all

Sitting: ____ Over 6 hrs/shift ____ 1-6 hrs/shift ____ Not at all

Repetitive hand movements: ____ Over 6 hrs/shift ____ 1-6 hrs/shift ____ Not at all

Reaching above shoulder level: ____ (10 + x/hr) ____ (1-9 x/hr) ____ Not at all

Other: _____

Are these restrictions permanent? ____ Yes ____ No

If no, when will the restrictions be reviewed for possible modification? Date: _____

Health Provider signature: _____ Date: _____

Please note that the employer does not guarantee that it will be able to accommodate restricted work nor create light duty work for the employee. Each case is evaluated on its individual merits and all reasonable accommodations will be considered.