FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION

An employee on Family and Medical Leave 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.

TO: Health Care Provider

Our employee, _____________________________________, began a period of medical care leave for his/her serious health condition on _________________________.
(date employee commenced leave)

As a condition of return to work, the employee must have a medical examination. This form must be completed by you, as his/her health care provider, before the employee is allowed to resume his/her job duties.

1. Employee Name: ____
2. Employee's Job Title: _______________________________________
3. Date of Medical Examination: _______________________________
4. Date employee may return from leave _______________________________________.
5. Please indicate with a check mark the status of the employee's release for duty.

    _______________ Full, unrestricted duty. (Skip question 6 and proceed to item 7.)
    _______________ Modified duty. (Complete question 6.)
    _______________ Not released for any type of duty. (Go to item 7.)

6. If you are releasing the employee to modified duty, you must complete the following:

    a. Estimated date that employee will be able to return to full, unrestricted duty: ____.
    b. Date of your next medical evaluation of the employee: ____.

Indicate the exact work restrictions which apply to the employee at this time on the chart listed 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)			
Standing (hrs)			
Sitting (hrs)			
Stooping (hrs)			
Kneeling (hrs)			
Repeated Bending (hrs)			
Climbing (hrs)			
Operating a motor vehicle, crane, tractor, etc.			
Other:			
Exposure Limitation (Specify):			

7. I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury at ________________________, this ______ day of
(List City and State)

__________________, ___.
(month) (year)

____
Signature of Health Care Provider

____
Date

____
Print Name of Health Care Provider

____
Phone Number (include area code)

_______________________ ______________________
Type of Practice License No.

____
Address

____
City State Zip

cc: Personnel File