Fitness-To-Return Certification

Instructions to Employee: Please complete this section before giving this form to your health care provider. Return this form to your department/institution before or on the day you return to work.

Employee's Name: _____ Employee ID: _____

Instructions to Department/Institution: Attach the job duty statements from the official Position Description (PD). This completed form is to be placed in a separate, confidential medical file with limited access from the usual personnel files for Family Medical Leave Act (FMLA) purposes and in accordance with 29 C.F.R. § 1630. 14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R 1635.9, if the Genetic Information Nondiscrimination Act applies.

Instructions to Health Care Provider: Please complete this form when the employee is seeking your release to return to work. Do not provide information about genetic tests, as defined in 29 C.F.R 1635.3(f), genetic services, as defined in 29 C.F.R. 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. 1635.3(b). Please be sure to sign the back of this form and return to the employee.

1. Date the condition began:_____

2. a. Check one of the following.

- ☐ The employee is able to work a full, regularly scheduled day with no restrictions beginning _____ (date).
- ☐ The employee is unable to return for any work until _____ (date).
- ☐ The employee is able to return to work on a reduced schedule for _____ hours per day from _____ (date) through _____ (date).
- ☐ The employee is able to return to work with restrictions from _____ (date) through _____ (date).

Please complete next section b.

b. Please indicate restrictions.

- ☐ no lifting or carrying objects: _____ max. lbs. Repetitions
- ☐ no pushing/pulling objects: _____ max. lbs. Repetitions
- ☐ no bending/stooping/squatting/twisting: Repetitions
- ☐ no kneeling for more than _____ hours each day
- ☐ no crawling for more than _____ hours each day
- ☐ no sitting for more than _____ hours each day
- ☐ no standing for more than _____ hours each day
- ☐ no walking for more than _____ hours each day
- ☐ no climbing stairs
- ☐ no working/climbing on elevated equipment (ladders, stools, roofs, poles, etc.) for more than _____ hours each day
- ☐ no reaching above the head or shoulders
- ☐ no reaching away from the body greater than _____ with ☐ right ☐ left arm
- ☐ no grasping objects with ☐ right ☐ left hand
- ☐ no fine manipulation with ☐ right ☐ left hand
- ☐ no assaultive, physical control, and/or arrest situations
- ☐ no driving a vehicle
- ☐ no operating machinery or equipment
- ☐ no working alone
- ☐ no use of firearms
- ☐ no typing, keyboarding, or entering data for more than _____ hours each day
- ☐ no use of a CRT or computer monitor for more than _____ hours each day
- ☐ no use, including repetitive, of _____ (extremity/joint)
- ☐ no weight bearing on _____ (extremity)

3. Other restrictions (specify):

_____
_____
_____
_____

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Based on my personal evaluation of the patient's condition, the above information is accurate and complete.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____