BOYD COUNTY PUBLIC SCHOOLS
The Leader In Learning

# INTENT TO RETURN AND FITNESS FOR DUTY/MEDICAL RELEASE

***Please read this form completely and return to Payroll/Benefits prior to returning to your job site.****

## TO BE COMPLETED BY EMPLOYER:

Employee Name:_____ Regular Work Hours: _____

Additional Information For Physician: _____

_____

**Job Description Attached To This Form**

## TO BE COMPLETED BY EMPLOYEE:

Printed Name of Employee:_____ Emp #: _____

Employee Phone #:_____ Work Location: _____

I _____ authorize/ _____ do not authorize (*check one*) the health care provider identified below to provide the information requested on this form for the purposes of determining my fitness for duty. Additionally, I authorize a designated BCPS employee to contact my health care provider to authenticate and/or clarify the information if needed.

I understand that if I do not agree to this authentication, my return to work may be delayed or denied.

Employee's Signature: _____ Date: _____

***Any employee who fraudulently obtains Family Medical Leave will be subject***

***to disciplinary action, up to and including termination.***

**TO BE COMPLETED BY THE HEALTH CARE PROVIDER:**

Patient's Name: _____

Please review the employee's work schedule and essential functions and answer the following:

Is employee able to perform the essential functions of the position that are attached? ___ YES ___ NO

*If yes, is the employee fully released to return to work on _____ (Date)*

*If no, the employee is released with restrictions* to return to work on _____ (Date)*

***(Complete this section if the employee is being released to modified or restricted 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/Bending (hrs) | | | |
| Climbing – Ladders, steps, etc. (hrs) | | | |
| Operating a motor vehicle, crane, tractor, mower, etc. | | | |
| Other: | | | |
| Exposure Limitation (Specify): | | | |

*Any release with restrictions will have to be approved by BCPS, as not all restrictions can be accommodated.*

**Additional Comments:**

**Health Care Provider Information:** Printed Name: _____

Signature:_____ Date: _____

Address: _____ Phone: _____