FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION

An employee on Family and / or Medical Leave because of his/her own medical condition must present this release to his/her supervisor prior to or on the day he/she returns to work.

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 signed medical release. This form must be completed by his/her health care provider, before the employee is allowed to resume his/her job duties.

1. Employee Name: ____

1. Employer and Job Title: ____

1. 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.

A copy of this employee's job description is attached. Please review prior to completion of work status.
Please note: Should employee not be released to his/her full duty position, the employer is not required to modify the position he/she was originally hired to perform.

_______________ 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:
____.
c. Indicate the exact work restrictions which apply to the employee at this time on the following chart.

Employee's Name:___________________________

(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.**

Signature of Health Care Provider   Date

Print Name of Health Care Provider   Phone Number

Type of Practice

Address

City   State   Zip