



FITNESS FOR DUTY FORM

Employee Name: _____ Campus/Position: _____

A. STATEMENT OF PHYSICIAN OR PRACTITIONER

Medical Facts Regarding Employee's Condition:

In consideration of essential job functions, please indicate any area of concern in light of employee's current condition. (job description attached)

- Has employee reached the end of his/her healing period? Yes ☐ No ☐
- Is the employee able to return to work without posing a significant risk or substantial harm to him/herself or others? Yes ☐ No ☐
If yes, when can the employee return to work? _____
If no, estimate the beginning and ending dates for the period of incapacity. _____

- Is the employee able to work his/her normal work schedule? Yes ☐ No ☐
If no, identify the number of hours per day and the number of hours per week that the employee can work, and the expected duration of the period for the reduced schedule.

- Is the employee able to perform all of the functions of his/her regular job? Yes ☐ No ☐
- Restrictions? Yes ☐ No ☐
If yes, the employee may return to work as of _____ (date) **with restrictions identified**, which are expected to last through _____ (date).

Comments:

Physician Signature: _____ Date: _____

Physician Printed Name & Contact Information: _____

Please return form to:
RiskManagement@wylieisd.net
Desk: 972-429-3073
Fax: 972-941-6073