**Return to Work Release/Fitness for Duty**

Instructions:

* Human Resources has provide this form to you, with any applicable job descriptions attached, to assess your readiness to return to work, or fitness to resume work duties.
* Have your health care provider review the attached job description(s) and complete this form. When completed, return to Human Resources.
* Health Care Provider: Please review the attached job description, complete this form and return it to your patient.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check one of the following:

* He/she is able to work a full, regular schedule with no restrictions, on \_\_\_\_\_\_\_\_\_\_\_\_ (date).
* He/she is unable to return to work until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date).
* He/she is able to return to work on a reduced schedule for \_\_\_\_\_ hours a day from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date) through\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date).
* The employee is able to return to work with restrictions from \_\_\_\_\_\_\_\_\_\_\_\_ (date) through\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date).

Please indicate restrictions, if any, below for:

* Standing (number of hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Walking (number of hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Sitting (number of hours): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Lifting (number of pounds): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Carrying (number of pounds): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Use of hands (repetitive motions, pushing, pulling): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_