Fitness for Duty/Return to Work Form

Medical authorization from attending physician is required for employees returning to work from family and medical leave. This form must be returned to Human Resources prior to or before returning to work.

Employee Section

Employee Name/Patient: (Last, First) ______________________________________________________

CWID: ________________________________     Date of Injury/Illness: _____ /_____ /______

Physician Section

☐ May resume work at full duty, **without** restrictions, effective date: _____ /___ /______

☐ Normal shift, regular duties

☐ May resume work **with** the following restrictions, effective date: _____ /___ /______

Expected duration of accommodations is: _________________________________________

☐ Full Time  OR  ☐ Part-Time @ _______ # hours /per day or _____ /per week

☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 lbs.)

☐ Light work (lifting less than 20 lbs.)

☐ Medium work (lifting less than 50 lbs.)

☐ Heavy work (lifting less than 100 lbs.)

☐ Other – Please describe: ______________________________________________________

____________________________________________________________________________

____________________________________________________________________________

He / She has a return appointment on (date) _____ /___ /______ at (time) __________.

_______________________________       _________________________________________________

Physician Name (print)         Physician Signature            Date

_____________________________________________________________________________________

Phone Number (include area code)                Street Address, City, State and Zip Code