ATTENDING PHYSICIAN'S FITNESS FOR DUTY CERTIFICATE

(This form certifies an employee's ability and fitness to return to work and is required in order for the employee to return to active work status.)

Patient's Name: _____

Diagnosis: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN/PRACTITIONER

A. The patient was seen and treated on _____and the following work status is recommended.

B. S/He may return to work on _____(Date) without restrictions.

C. S/He may return to work on _____(Date) capable of performing restricted work as indicated below with the following restrictions.

WORK LEVEL		RESTRICTIONS
Sedentary Work. Lifting ten (10) pounds maximum and occasionally lifting and/or carrying small articles or small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met. **Light Work.** Lifting twenty (20) pounds maximum with frequent lifting and/or carrying objects weighing up to ten (10) pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when in involves sitting most of the time with a degree of pushing or pulling of the arm and/or leg. Medium Work. Lifting fifty (50) pounds maximum. Frequent lifting and/or carrying of objects up to fifty (50) pounds.		In an eight (8) hour day the patient may: **Stand/Walk** [ ] None [ ] 1-4 hours [ ] 4-6 hours [ ] 6-8 hours **Sit** [ ] 1-3 hours [ ] 3-5 hours [ ] 5-8 hours **Drive** [ ] 1-3 hours [ ] 3-5 hours [ ] 5-8 hours **Patient is able to:** Frequently Occasionally Not at All Bend [ ] [ ] [ ] Squat [ ] [ ] [ ] Climb [ ] [ ] [ ]
Other instructions or restrictions:		

D. These restrictions are in effect until _____ or until the patient is reevaluated on. _____.
(Date) (Date)

E. S/He is totally incapacitated and unable to return to work at this time. Patient will be reevaluated on _____.
(Date)

Physician's Signature: _____ Date: _____ Physician's Phone # _____

I hereby authorize my physician to release any information acquired in the course of my examination or treatment.

Employee's Signature _____- Date _____