Note: Please return this form to Human Resources or Fax to 745-5582

Fitness for Duty- Medical Certification

_____ , has been authorized to seek medical attention on this date_____ for a work related injury. Please examine, diagnose and treat as required. We have developed an Early Return-To-Work Program to help in the recovery and rehabilitation of this individual and to assist your patient in the transition to a return to full duty employment if necessary. If there are any questions, please contact the Human Resources Department at (270) 745-8841.

_____
Authorization

Diagnosis by attending physician:_____

_____

Physician's Recommendation:

[ ] May return to normal duties immediately.

[ ] Remain off work until next scheduled visit.

[ ] May return to work only under the following restrictions:

Please complete the bottom portion of this form if restrictions and limitations are applicable.

In a given day, how many total hours can this employee work? [_____]

In an eight-hour workday, how many hours can this employee perform the following:

Sit [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] Continuously [ ] With Rests

Stand [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] Continuously [ ] With Rests

Walk [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] Continuously [ ] With Rests

(N = Never, O = Occasionally, F = Frequently, C = Continuously)

Lifting/Carrying	N	O	F	C	**Activity**	N	O	F	C
10 lbs. or less					Bend				
11 - 20 lbs.					Squat				
21 - 40 lbs.					Kneel				
41 - 60 lbs.					Twist/Turn				
61 - 100 lbs.					Climb				
Pushing/Pulling					Crawl				
10 - 25 lbs.					Stretch				
26 - 40 lbs.					Reaching				
41-60 lbs.					Over Head lifts				
61-100 lbs.					Reach Above Shoulder				

(1). Never- O hours (2). Occasionally- Up to 2.5 hours (3). Frequently- Up to 5.5 hours (4). Continuously- More than 5.5 hours

Comments:_____

The above listed restrictions are in effect until _____. The patient will be re-evaluated on_____.

If modified duties are not recommended, stay off work until _____ (please contact Human Resources Department). Date of follow-up visit: _____.

Physician Name: _____ **Phone number:** _____

Physician's signature: _____ **Date:** _____