

## Fitness for Duty Authorization

<b>PART I: GENERAL INFORMATION</b>		5. Doctor's Name	Date Being Sent
1. Employee's Name		6. Clinic/Facility Name	
2. Date of Initial Absence	3. Social Security Number	7. Clinic/Facility/Doctor Phone & Fax	
4. Employer Name:	8. Clinic/Facility/Doctor Address (street address)		9. City State Zip

**PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)**

13. The employee's medical condition resulting in an approved FMLA absence:  
 (a) will allow the employee **to return to work** as of \_\_\_\_\_ (date) **without restrictions**.  
 (b) will allow the employee **to return to work** as of \_\_\_\_\_ (date) **with the restrictions identified in PART III**, which are expected to last through \_\_\_\_\_ (date).  
 (c) has prevented and still prevents the employee **from returning to work** as of \_\_\_\_\_ (date) and is expected to continue through \_\_\_\_\_ (date).  
 The following describes how this injury **prevents the employee from returning to work**:

**PART III: ACTIVITY RESTRICTIONS\* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)**

<b>14. POSTURE RESTRICTIONS (if any):</b>	<b>17. MOTION RESTRICTIONS (if any):</b>	<b>19. MISC. RESTRICTIONS (if any):</b>
Max Hours per day: 0 2 4 6 8 Other _____	Max Hours per day: 0 2 4 6 8 Other _____	Max hours per day of work: _____
Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	Sit/Stretch breaks of _____ per _____
Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	Climbing (stairs/ladders) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	Must wear splint/cast at work <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>
Kneeling/Squatting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	Grasping/Squeezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	Must use crutches at all times <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>
Bending/Stooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	Wrist (flexion/extension) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	No driving/operating heavy equipment <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>
Pushing/Pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	Can only drive automatic transmission <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>
Twisting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	Overhead Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	No work / hours/day work: _____
Other: _____	Keyboarding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	in extreme hot/cold environments <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>
<b>15. RESTRICTIONS SPECIFIC TO (if applicable):</b>	Other: _____	at heights or on scaffolding <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/> Limits: _____
L Hand/Wrist <input type="checkbox"/> R Hand/Wrist <input type="checkbox"/>	<b>18. LIFT/CARRY RESTRICTIONS (if any):</b>	Must keep _____ :
L Arm <input type="checkbox"/> R Arm <input type="checkbox"/> Neck <input type="checkbox"/>	May not lift/carry objects more than _____ lbs.	Elevated Clean & Dry <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>
L Leg <input type="checkbox"/> R Leg <input type="checkbox"/> Back <input type="checkbox"/>	for more than _____ hours per day	No skin contact with: _____
L Foot/Ankle <input type="checkbox"/> R Foot/Ankle <input type="checkbox"/>	May not perform any lifting/carrying <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>	Dressing changes necessary at work <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>
Other: _____	Other: _____	No Running <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>
<b>16. OTHER RESTRICTIONS (if any):</b>	<b>20. MEDICATION RESTRICTIONS (if any):</b>	
_____	Must take prescription medication(s) <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>	Advised to take over-the-counter meds <input type="checkbox"/> Y <input type="checkbox"/> or N <input type="checkbox"/>

*\* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.*

Medication may make drowsy (possible Safety/driving issues)  Y  or N

**PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION**

**22. Expected Follow-up Services Include:**

Evaluation by the treating doctor on \_\_\_\_\_ (date) at \_\_\_\_\_ : \_\_\_\_\_ am/pm

Referral to/Consult with \_\_\_\_\_ on \_\_\_\_\_ (date) at \_\_\_\_\_ : \_\_\_\_\_ am/pm

Physical medicine \_\_\_ X per week for \_\_\_ weeks starting on \_\_\_\_\_ (date) at \_\_\_\_\_ : \_\_\_\_\_ am/pm

Special studies (list): \_\_\_\_\_ on \_\_\_\_\_ (date) at \_\_\_\_\_ : \_\_\_\_\_ am/pm

None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-up	Role of Doctor: <input type="checkbox"/> Treating doctor <input type="checkbox"/> Referral doctor <input type="checkbox"/> Consulting doctor <input type="checkbox"/> Other doctor _____
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