Fitness for Duty/Return to Work Form

Medical authorization from treating physician is required for employees returning to work from leave of absence. This form must be returned to HR Benefits prior to or before returning to work.

Employee Section

Employee Name/Patient: (Last, First) _____

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

Job Title: _____

Physician Section *Please review the accompanying job description.*

☐ 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 restrictions: _____

- ☐ 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: _____

_____

_____

The employee 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

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