## Fitness-For-Duty Certification

**Instructions to Employee:** Please complete this section before giving this form to your health care provider. Return this form to Human Resources before you return to work.

Employee Name _____ Employee ID _____

**Instructions to Department/Institution**: Attach the job duty statements from the official Position Description Questionnaire (PDQ). This completed form is to be placed in a separate, confidential medical file with limited access from the usual personnel files for Family Medical Leave Act (FMLA) purposes and in accordance with 29 C.F.R. § 1630. 14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R 1635.9 if the Genetic Information Nondiscrimination Act applies.

**Instructions to Health Care Provider:** Please complete this form when the employee is seeking your release to return to work or when requesting workplace accommodation. Do not provide information about genetic tests, as defined in 29 C.F.R 1635.3(f), genetic services, as defined in 29 C.F.R. 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. 1635.3(b). Please be sure to sign the bottom of this form and return to the employee.

1. Date the condition began: _____

2. a) Check one of the following:

   - ☐ The employee is able to work a full, regularly scheduled day with no restrictions beginning _____(date).
   - ☐ The employee is unable to return for any work until _____ (date).
   - ☐ The employee is able to return to work on a reduced schedule from _____ (date) through _____ (date).
   - ☐ The employee is able to return to work with restrictions as of _____ (date).

   b) Please indicate restrictions:

| Activity | Able to Perform | Not Able to Perform | Other Considerations |
|---|---|---|---|
| Understanding | | | |
| Remembering | | | |
| Sustained concentration | | | |
| Follow-through on instructions | | | |
| Decision-making | | | |
| Receiving supervision | | | |
| Interpersonal functioning (relating to co-workers and students) | | | |
| Pace | | | |
| Reliability | | | |
| Stress Tolerance | | | |

| Activity | Full Restrictions | No Restrictions | Partial Restrictions (Please Explain) |
|---|---|---|---|
| Lifting or carrying objects | | | |
| Pushing/pulling objects | | | |
| Bending/stooping/squatting/twisting | | | |
| Kneeling | | | |
| Crawling | | | |
| Sitting | | | |
| Standing | | | |
| Walking | | | |
| Climbing stairs | | | |
| Working/climbing on elevated equipment (ladders, stools, roofs, poles, etc.) | | | |
| Reaching about the head or shoulders | | | |
| Reaching away from the body | | | |
| Grasping objects with no fine manipulation | | | |
| Assaultive, physical control, and/or arrest situations | | | |
| Driving a vehicle | | | |
| Operating machinery or equipment | | | |
| Working alone | | | |
| Use of firearms | | | |
| Typing, keyboarding, or entering data | | | |
| Use of CRT or computer monitor | | | |
| Use, including repetitive of _____ (extremity/joint) | | | |
| Weight bearing on _____ (extremity/joint) | | | |

3. Other restrictions (specify):

_____

_____

_____

Based on my personal evaluation of the patient's condition, the above information is accurate and complete.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

Provider's Signature _____ Date _____