This form should be completed by the medical provider in its entirety.

FITNESS FOR DUTY CERTIFICATE

Employee's Name: _____

Able to work without restrictions on: _____

Able to work with restrictions from: _____ to: _____

Date of next evaluation: _____

EMPLOYEE'S CAPABILITIES

LIFT/CARRY	Not At All	< 1 hr	1-3 hrs	3-6 hrs	6-8+ hrs
0-10 lbs	☐	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐	☐
21-40 lbs	☐	☐	☐	☐	☐
41-60 lbs	☐	☐	☐	☐	☐
> 60 lbs	☐	☐	☐	☐	☐
PUSH/PULL					
0-10 lbs	☐	☐	☐	☐	☐
11-20 lbs	☐	☐	☐	☐	☐
21-40 lbs	☐	☐	☐	☐	☐
41-60 lbs	☐	☐	☐	☐	☐
> 60 lbs	☐	☐	☐	☐	☐

LIFT/CARRY POSITIONS	0-10 lbs	11-20 lbs	21-40 lbs	41-60 lbs	> 60 lbs
Below Waist	☐	☐	☐	☐	☐
At Waist	☐	☐	☐	☐	☐
Above Shoulder	☐	☐	☐	☐	☐

OTHER	Not At All	< 1 hr	1-3 hrs	3-6 hrs	6-8+ hrs
Kneel/ Squat	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐
Ladder/Stair Climb	☐	☐	☐	☐	☐
Drive as part of work	☐	☐	☐	☐	☐

TRUNK	Normal	Limited	None
Bend	☐	☐	☐
Stretch	☐	☐	☐
Twist	☐	☐	☐

EXPLAIN IF LIMITED OR NONE: _____

NECK	Normal	Limited	None
Bend	☐	☐	☐
Stretch	☐	☐	☐
Twist	☐	☐	☐

EXPLAIN IF LIMITED OR NONE:

ARM/HAND	Not At All	< 1 hr	1-3 hrs	3-6 hrs	6-8+ hrs
Right	☐	☐	☐	☐	☐
Left	☐	☐	☐	☐	☐
Both	☐	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐	☐
Grasping	☐	☐	☐	☐	☐
Pinching	☐	☐	☐	☐	☐

Additional Restrictions or Comments: _____

_____

_____ _____

Signature of Health Care Provider Date

_____ _____

Printed Name Type of Practice

_____ _____

Address Telephone Number

_____