Fitness for Duty Certification

To be completed by the Employee:

Return the completed form to Human Resources prior to your return to work.

Employee name: ________________________ Blinn ID# ________________

Department: _________________ Job Title: ___________________________

To be completed by the Health Care Provider:

Please check one of the following:

__ The employee can work a full, regular schedule with no restrictions, beginning ____(date)

__ The employee is unable to return to work until _________________________________(date)

__ The employee can return to work on a reduced schedule for _____ hours a day from _____________________________(date) through________________________________ (date)

__ The employee can return to work with restrictions from___________________________ (date) through__________________________________ (date).

Please indicate restrictions, if any, below for:

Standing (number of hours): ________________________________

Walking (number of hours): _________________________________

Sitting (number of hours): __________________________________

Lifting (number of pounds): _________________________________

Carrying (number of pounds): _______________________________

Use of hands (repetitive motions, pushing, pulling): ____

Any other restrictions: ______________________________________

Signature of Health Care Provider: _______________________________________

Printed Name of Health Care Provider: ____________________________________

Contact Number of HealthCare Provider: __________________________________

Date: ____

Please complete this form and return it to the patient.