Fitness for Duty

Form to be completed by a health care provider. This form is for return-to-work purposes from a medical leave of absence due to an illness or injury, whether work or non-work related.

Health Care Professionals: Your patient has three options regarding his/her ability to return to work:

- **Full Release:** The patient has no work restrictions. He/she can return to his or her prior position because you, the health care provider, certify that he/ she can perform the essential functions of his/her job.

- **Modified Duty:** The patient has some work restrictions. Work restrictions must be specifically notated on page two of this form. Each modified duty work restriction request will be reviewed carefully to determine if the employee can perform the essential functions of the job and return to work.

- **Not Released:** The patient is not released to work in any capacity due to physical or behavioral limitations.

GINA Provision

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by GINA. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Submission

The Fitness for Duty Certification should be submitted confidentially to:

CSU Human Resources
555 S Howes St | Fort Collins, CO 80523-6004
Fax: (970) 491-6302 | Phone: (970) 491-6947 | MyHR@colostate.edu

1. Employee/Patient Name:____
2. Date of Medical Examination:____
3. Please verify the status of the employee’s release for duty:

- ☐ Full, unrestricted duty effective:____________________
- ☐ Modified duty effective:____________________. Next evaluation date:______________
- ☐ Not currently released for any type of duty. Next evaluation date:______________

Physical Evaluation

RESTRICTIONS	Full	Partial *(please specify)*	None
Sedentary – Lifting 0-10 pounds			
Light– Lifting 10-20 pounds			
Moderate – Lifting 20-50 pounds			
Heavy – Lifting 50-100 pounds			
Pulling/Pushing, Carrying			
Twisting/Turning			
Reaching/working above shoulder			
Repetitive activity			
Sustained postures			
Walking			
Standing			
Stooping			
Kneeling			
Repeated bending			
Climbing			
Crawling			
Crouching			
Operating a motor vehicle			
Operating equipment			
Gripping			
Balancing			
Finger manipulation (typing)			

Behavioral/Cognitive Evaluation

	Able to perform	**Other Considerations** *(please specify)*	**Not able to perform**
Reasoning			
Alertness			
Understanding			
Memory			
Sustained concentration			
Ability to follow through on instructions or directives			
Decision making			
Receiving supervision			
Ability to relate to and work with others, including coworkers and students			
Pain (frequency, degree, signs)			

Other Restrictions, Considerations Notes, and/or Additional Concerns, including restrictions or clarifications that are medically necessary:

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I hereby certify that the facts in this Fitness for Duty Certification are true and correct.

_____________________________________ _________________________

Health Care Provider Signature Date

_____________________________________ _________________________

Printed Name of Health Care Provide Phone Number