State of Colorado Fitness-To-Return Certification

Instructions to Employee: Return this form to your department/institution before or on the day you return to work.

Employee's 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.

Instructions to Health Care Provider: Please complete this form when the employee is seeking your release to return to work.

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 for _____ hours per day from ______ (date) through ______ (date).
- ☐ The employee is able to return to work with restrictions from ______ (date) through _____(date). Please complete next section (b).

(b) Please indicate restrictions.

- ☐ no lifting or carrying objects: _____ max. lbs. Repetitions
- ☐ no pushing/pulling objects: _____ max. lbs. Repetitions
- ☐ no bending/stooping/squatting/twisting: Repetitions
- ☐ no kneeling for more than _____ hours each day
- ☐ no crawling for more than _____ hours each day
- ☐ no sitting for more than _____ hours each day
- ☐ no standing for more than _____ hours each day
- ☐ no walking for more than _____ hours each day
- ☐ no climbing stairs
- ☐ no working/climbing on elevated equipment (ladders, stools, roofs, poles, etc.) for more than hours each day
- ☐ no reaching above the head or shoulders
- ☐ no reaching away from the body greater than ________ with ☐ right ☐ left arm
- ☐ no grasping objects with right left hand
- ☐ no fine manipulation with right left hand
- ☐ no assaultive, physical control, and/or arrest situations
- ☐ no driving a vehicle
- ☐ no operating machinery or equipment
- ☐ no working alone
- ☐ no use of firearms
- ☐ no typing, keyboarding, or entering data for more than ________ hours each day
- ☐ no use of a CRT or computer monitor for more than ________ hours each day
- ☐ no use, including repetitive, of _____________ (extremity/joint)
- ☐ no weight bearing on _____________ (extremity)
- ☐ Other restrictions (specify):

3. Other instructions:

Revised January 20, 2009

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

Signature of Health Care Provider ______________________________ **Date** ____________________

Printed Name ______________________________________ **Type of Practice** ____________________

Address: ____

Telephone: ( ) ______________________________________ **Fax:** ( ) ____________________________

Email: ____

 Revised January 20, 2009