FITNESS FOR DUTY FORM

Patient Name: _____ Job Title: _____

Part I: Note to Health Care Provider

The information requested below is required by O'Reilly to determine the team member's (employee's) fitness for duty. Please complete this form and return it to the patient. O'Reilly maintains **job descriptions** that may be reviewed by the treating medical provider when making work status evaluations. If necessary, advise the patient to provide one from O'Reilly.

Part II: Work Status Information

Complete all appropriate statements:

a.) The team member will be off work from 01/27/23 to 02/16/23.
b.) The team member is allowed to return to work **without** restrictions on ___/___/___.
c.) The team member is allowed to return to work with **temporary restrictions** on ___/___/___ ending on ___/___/___.
d.) The team member is allowed to return to work with **permanent restrictions** on ___/___/___.

Part III: Work Restrictions (Complete if (c) or (d) of Part II is applicable)

Disregard any particular restriction that does not apply.

POSTURE RESTRICTIONS:

Max hours per day	0	2	4	6	8	OTHER
Standing	☐	☐	☐	☐	☐	_____
Sitting	☐	☐	☐	☐	☐	_____
Kneeling/Squatting	☐	☐	☐	☐	☐	_____
Bending/Stooping	☐	☐	☐	☐	☐	_____
Pushing/Pulling	☐	☐	☐	☐	☐	_____
Twisting	☐	☐	☐	☐	☐	_____

MOTION RESTRICTIONS:

Max hours per day	0	2	4	6	8	OTHER
Walking	☐	☐	☐	☐	☐	_____
Climb Stairs/Ladders	☐	☐	☐	☐	☐	_____
Grasp/Squeeze	☐	☐	☐	☐	☐	_____
Wrist Flex/Extension	☐	☐	☐	☐	☐	_____
Reaching	☐	☐	☐	☐	☐	_____
Overhead Reaching	☐	☐	☐	☐	☐	_____
Keyboarding	☐	☐	☐	☐	☐	_____

MISCELLANEOUS RESTRICTIONS:

- ☐ Max hours per day of work: _____
- ☐ Stretch breaks of_____ per_____
- ☐ Must wear splint/cast at work
- ☐ Must use crutches at all times
- ☐ No work in extreme hot/cold environments
- ☐ Must keep_____ (Body Part)
  - ☐ Elevated ☐ Clean & Dry
- ☐ No skin contact with:_____

LIFT /CARRY RESTRICTIONS:

- ☐ May not lift/carry objects more than _____ lbs. for more than _____ hours per day
- ☐ May not perform any lifting/carrying

RESTRICTIONS SPECIFIC:

☐ Hand/Wrist	Left	Right
☐ Arm	Left	Right
☐ Leg	Left	Right
☐ Foot/Ankle	Left	Right
☐ Neck		
☐ Back		

DRIVING RESTRICTIONS:

- ☐ No driving
- ☐ Max hours driving per day: _____
- ☐ No operating heavy equipment
- ☐ Can only drive automatic transmission
- ☐ Medication may make drowsy (Safety Issue)

Other Restrictions / Comments:

_____

_____

_____

_____

_____

These restrictions are based on the Health Care Provider's best understanding of the team member's physical job requirements as indicated in essential functions outlined in the attached job description.

Medical Provider Signature

425-818-8991
Medical Facility Telephone Number

Kristopher Day, MD, FACS
Medical Provider Name (print)

02/23/23
Date Signed

In compliance with The Genetic Information Nondiscrimination Act, 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.