Fitness for Duty Certification

NAME: Leidy Mota _____ SS#: _____

By my signature below, I hereby certify that the employee named above:

☐ Is able to return to work and safely perform all of the essential functions of their position on _____ (date)

☐ Is able to return to work and safely perform all of the essential functions of their position **with the following restrictions** on _____ (date):

____ No Bending > _____ Degrees Forward

____ No Forceful Exertion of _____ Arms > _____ pounds

____ No Gripping with _____ Hand

____ No Lifting > _____ pounds

____ No Reaching Overhead

____ No Repetitive Motion of _____ Arms/Hand/Fingers

____ No Standing > _____ Hours at A Time

____ No Squatting/Stooping

____ No Twisting > _____ Degrees from Side to Side

____ No Walking > _____ Hours at A Time

____ Other _____

_____

The above restriction(s) is/are_____ Permanent

_____ Temporary and it is expected that the employee will be able to do their essential job duties within/on _____ (indicate timeframe or date).

Next Appointment _____

Physician's Signature _____ Date: _____

PRINTED Physician's Name or Office Stamp Must Go Here:

Printed Name: | **Office Stamp:**

_____