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| **PATIENT’S NAME** :(First) (Middle Initial) (Last)  **Appendix B**  **FITNESS FOR DUTY** | | | | | **DATE OF INJURY/ILLNESS:** | |
| **AGENCY/INSTITUTION NAME:** | |
| **DIAGNOSIS:** | | | | | | |
| **TREATMENT:** | | | | | | |
| **WORK RELATED  NON WORK RELATED** | | | | | | |
| **No Restrictions/Return to Previous Work  Return to Work Subject to Following Restrictions:** | | | | | | |
| **DEGREE** | | | | **RESTRICTIONS/LIMITATIONS** | | |
|  | **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally, and other sedentary criteria are met. | | | 1. In a workday patient may: 2. **Stand/Walk**  None  1-4 Hrs.  6-8 Hrs.  Unlimited 3. **Sit**  1-3 Hrs.  3-5 Hrs.  5-8 Hrs.  Unlimited 4. **Drive**  1-3 Hrs.  3-5 Hrs.  5-8 Hrs.  Unlimited | | |
|  | **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree or pushing and pulling of arm and/or leg controls. | | | 1. Patient may use hands for repetitive:   Simple Grasping  Fine Manipulation  Pushing/Pulling   1. Patient may use feet for repetitive movement as in operating foot controls:   Yes  No | | |
|  | **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds. | | | 1. Patient is able to: **Frequently Occasionally Not at all**   a. Bend  b. Squat | | |
|  | **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds. | | | c. Climb  d. Twist Body | | |
|  | **Very Heavy Work.** Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more. | | | Duration levels in relation to a job’s workday schedule: **frequently** (1/3 to 2/3), **occasionally** (2% to 1/3)   1. Patient has cognitive/mental limitations:  Yes  No | | |
| **OTHER INSTRUCTIONS, RESTRICTIONS/LIMITATIONS:** | | | | | | |
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| **RETURN TO WORK DATE: ANTICIPATED DURATION OF RESTRICTION:** | | | | | | |
| **FOLLOW-UP APPOINTMENT DATE: REFERRED TO:** | | | | | | |
| PHYSICIAN’S NAME | | | ADDRESS | | | TELEPHONE NO. |
| PHYSICIAN’S SIGNATURE | | | | | | DATE |
| **AUTHORIZATION TO RELEASE INFORMATION** | | | | | | |
| I hereby authorize my attending physician and/or hospital to release the above information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or his representative. I understand the restrictions above apply 24 hours per day and it is my responsibility to report my availability to work to my employer. | | | | | | |
| PATIENT’S SIGNATURE | | | | | | DATE |