FITNESS FOR DUTY CERTIFICATION TO RETURN FROM MEDICAL LEAVE

Team Member Name _____ **Team Member ID** _____
Last, First, Middle Initial (Please Print)

Team Member Date of Birth: ___/___/_____

A team member on a Medical Leave due to his/her own serious medical condition must present this release to Leave of Absence Administration before he/she returns to work. A team member may not work without this release.

TO: Health Care Provider

As a condition of return to work, the team member must have a medical clearance. This form must be completed by you, as his/her health care provider, before the team member is allowed to resume his/her job duties.

1. Team Member Name: _____
2. Team Member's Job Title: _____
3. Date of Last Medical Examination: _____
4. Date Team Member May Return from Leave: _____
5. Please indicate with a checkmark, the status of the team member's release for duty.

   _____ Full, unrestricted duty. (Skip question 6 and proceed to item 7.)

   _____ Modified duty. (Complete question 6 and 7.)

   _____ Not released for any type of duty. (Go to item 7.)

6. If you are releasing the team member to modified duty, please complete the following:
   a. Estimated date that team member will be able to return to full, unrestricted duty: _____.
   b. Date of your next medical evaluation of the team member: _____.
   c. Indicate the exact work restrictions which apply to the team member at this time using the chart on page 2 of this form.

Atrium Health has a Return to Work Program that provides our team members with work restrictions the opportunity to return to work in a reduced capacity. Our program is designed to allow our team member to safely perform modified or alternative work within their work restrictions while they recover. We promote an expeditious and productive return to work philosophy.

Is this team member a candidate for the Return to Work Program? ☐ **Yes** ☐ **No**

Complete this section if the team member is being released to modified duty.

- ☐ **None – Explain:** _____
- ☐ Return to work no greater than _____ hours/day
- ☐ No lifting greater than _____ pounds ☐ right ☐ left ☐ both
- ☐ No pushing/pulling greater than _____ pounds ☐ right ☐ left ☐ both
- ☐ No reaching/working above shoulder ☐ right ☐ left ☐ both
- ☐ No work involving use of hand/arm ☐ right ☐ left ☐ both
- ☐ Sit down work only
- ☐ No walking/standing over _____ minutes/hours
- ☐ No stooping ☐ No repeated bending ☐ No climbing ☐ No twisting, bending

Other: _____

_____

Additional Comments/Notes:

_____

_____

_____

_____

_____

_____

7. I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury at _____, this _____ day of _____, _____.
(List City and State) (month) (year)

ATTENDING PROVIDER:

Print or Type Name: _____ Signature: _____

Type of Practice/Medical Specialty: _____

Street Address: _____ City / State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Date _____

MUST BE FURNISHED UNDER AUTHORITY OF LAW: SS# or Employer ID # _____

Fax completed form to (704) 446-6624 or call (704) 631-0262 to discuss leave.