

**PHYSICIAN'S FITNESS FOR DUTY RELEASE FORM**

This information is confidential and will be used only in determining if this employee is capable of returning to work in the performance of the essential functions of their job in a safe manner.

Employee Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_

After having reviewed the accompanying job description, this employee is released to return to work:

CIRCLE ONE:

**Full Duty:** with no restriction on (date) \_\_\_\_\_

OR

**Transitional Duty:** with restrictions listed in the comments section on this form.

This employee is released to work transitional duty with restrictions on (date) \_\_\_\_\_

Date of expected full duty release \_\_\_\_\_

Comments:

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Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_