SOUTHEAST ALABAMA MEDICAL CENTER

Fitness For Duty To Return From Leave Certification

An employee on Family and Medical Leave because of his/her own serious medical condition must present this release to Employee Health & Wellness **prior to or on the day** he/she returns to work. The physician will complete the FDRLC Form or a comparable form that the physician office provides. This form must state the return to work is without restrictions or it must specifically describe any restrictions. An employee may NOT work without this release.

TO: Health Care Provider

Our SAMC employee, _____, began a period of medical care leave for his/her serious health condition on _____.
(date employee commenced leave)

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

1. Employee Name: _____
2. Employee's Job Title: _____
3. Date of Medical Examination: _____
4. Date employee may return from leave _____.
5. Please indicate with a check mark the status of the employee's release for duty.

   _____ Full, unrestricted duty. (Skip question 6 and proceed to item 7.)
   _____ Modified duty. (Complete question 6.)
   _____ Not released for any type of duty. See back of form

6. If you are releasing the employee to **modified duty**, you must complete the following:

   a. Indicate on the back of this form the <u>exact</u> work restrictions which apply.

   b. Please indicate here if modified duty includes restricted work hours. Hours per day_____.

   c. Estimated date that employee will be able to return to full, unrestricted duty: _____.

   d. Date of your next medical evaluation of the employee: _____.

EMPLOYEE NAME: _____

Physical Examinations	No Restrictions	Partial Restrictions	Comments
Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs)			
Standing (hrs)			
Sitting (hrs)			
Stooping (hrs)			
Kneeling (hrs)			
Repeated Bending (hrs)			
Climbing (hrs)			
Operating a motor vehicle, crane, tractor, etc.			
Other:			
Exposure Limitation (Specify):			

_____ _____

Signature of Health Care Provider Date

_____ _____

Print Name of Health Care Provider Phone Number

_____

Type of Practice

_____

Address

_____

City State Zip