Tuba City Regional Health Care Corporation
Fitness For Work Duty Form

Instructions to Employee: ***Please fill in your name, birthdate, job title, and date of evaluation. Please have your provider complete this form.***

Employee Name: _____ **Birthdate:** _____

Job Title: _____ **Date of Evaluation:** _____

Instructions to Provider: ***Please complete this form before the employee leaves the office today.*** **Give *the employee a* copy.**

Diagnosis: _____

Reason for Evaluation: _____

May start work with the below restriction and/or limitation on [Date}: _____

Employee Work Status*:* **This *patient has been* instructed *by* this *Medical Provider* to *(see below):***

☐ **May return to Full Duty** with no limitations or restrictions. ☐ **May return to work** _____ hours at a time. ☐ **May not work** at this time.

☐ **Return to Modified Work** with restrictions listed below. (Please check one for each item) ☐ **May work** _____hours of a _____shift.____

		Restricted from doing:	**Limited in doing:**
Standing	☐ No Restrictions	☐ No standing	Limited to ____ Hours/Shift
Sitting	☐ No Restrictions	☐ No sitting	Limited to ____ Hours/Shift
Alternate Stand/Sit	☐ No Restrictions	☐ No standing/sitting	Limited to ____ Hours/Shift
Walking	☐ No Restrictions	☐ No walking	Limited to ____ Hours/Shift
Alternate Walk/Sit	☐ No Restrictions	☐ No walking/sitting	Limited to ____ Hours/Shift
Bending (Back)	☐ No Restrictions	☐ No bending	Limited to ____ Hours/Shift
Squatting (Knees)	☐ No Restrictions	☐ No squatting	Limited to ____ Hours/Shift
Reaching (Upper)	☐ No Restrictions	☐ No reaching	Limited to ____ Hours/Shift
Overhead Reaching	☐ No Restrictions	☐ No overhead reaching	Limited to ____ Hours/Shift
Pushing (Back)	☐ No Restrictions	☐ No pushing	Limited to ____ Hours/Shift
Pulling (Back)	☐ No Restrictions	☐ No pulling	Limited to ____ Hours/Shift
Carrying charts/items	☐ No Restrictions	☐ No carrying charts/items	Limited to ____ Hours/Shift
Driving	☐ No Restrictions	☐ No driving	Limited to ____ Hours/Shift
Grasping (Hands)	☐ No Restrictions	☐ No grasping	Limited to ____ Hours/Shift
Computer/Data Keying (Hands)	☐ No Restrictions	☐ No computer/data keying	Limited to ____ Hours/Shift
Climbing	☐ No Restrictions	☐ No climbing	Limited to ____ Hours/Shift
Viewing Computer	☐ No Restrictions	☐ No viewing computer	Limited to ____ Hours/Shift
Telephone Usage	☐ No Restrictions	☐ No telephone usage	Limited to ____ Hours/Shift
Other Restrictions	☐ No Restrictions		Limited to ____ Hours/Shift

Frequency of Lifting

Lifting as indicated above is limited to (choose one): ☐ No Restrictions; ☐5-10 lbs. Limited to_____ Hrs/Shift; ☐Occasionally (1 - 2x/hr); ☐Frequently (3 - 4x/hr); ☐Continuously (5+ x/hr); ☐Other _____ **DME Needed:** _____

Re-evaluation/ Return to Full Duty (please fill in dates)

The employee will be re-evaluated on: _____May return to full duty on: _____

Provider Printed Name: _____ Provider Signature: _____ Date:_____

Revision (10/15/2024)