STATE OF COLORADO Fitness-To-Return Certification

Instructions to Employee: Return the completed form to your agency before or on the day you return to work. Knowingly providing false information directly, or through another party, may delay your return and result in corrective and/or disciplinary action.

Instructions to Employing Agency: Attach the task statements from the official Position Description Questionnaire. This completed form is to be placed in a separate, confidential medical file with limited access.

Instructions to Health Care Provider: Please complete this form when the employee is seeking your release to return to work.

Employee's Name	Employee ID Number

1. **Date** the condition began.

2(a) Check one of the following.

- ☐ The employee is able to work a full, regularly scheduled day with no restrictions beginning _____ (date).
- ☐ The employee is unable to return for any work until _____ (date).
- ☐ The employee is able to return to work on a reduced schedule for _____ hours per day from _____ (date) through _____ (date).
- ☐ The employee is able to return to work with restrictions from _____ (date) through _____(date). Please complete next section (b).

(b) Please indicate restrictions.

- ☐ no lifting or carrying objects: _____ max. lbs. Repetitions _____
- ☐ no pushing/pulling objects: _____ max. lbs. Repetitions _____
- ☐ no bending/stooping/squatting/twisting: Repetitions _____
- ☐ no kneeling for more than _____ hours each day
- ☐ no crawling for more than _____ hours each day
- ☐ no sitting for more than _____ hours each day
- ☐ no standing for more than _____ hours each day
- ☐ no walking for more than _____ hours each day
- ☐ no climbing stairs
- ☐ no working/climbing on elevated equipment (ladders, stools, roofs, poles, etc.) for more than ___hours each day
- ☐ no reaching above the head or shoulders
- ☐ no reaching away from the body greater than _____ with ☐ right ☐ left arm
- ☐ no grasping objects with ☐ right ☐ left hand
- ☐ no fine manipulation with ☐ right ☐ left hand
- ☐ no assaultive, physical control, and/or arrest situations
- ☐ no driving a vehicle
- ☐ no operating machinery or equipment
- ☐ no working alone
- ☐ no use of firearms
- ☐ no typing, keyboarding, or entering data for more than _____ hours each day
- ☐ no use of a CRT or computer monitor for more than _____ hours each day
- ☐ no use, including repetitive, of _____ (extremity/joint)
- ☐ no weight bearing on _____ (extremity)
- ☐ Other restrictions (specify):

3. Other instructions:

Based on my personal evaluation of the patient's condition, the above information is accurate and complete.

Health Care Provider Signature	Date
Printed Name	Type of Practice
Address	Phone