



Fitness for Duty Certification

Department of Human Resources

Employee Name: _____

Employee must provide this completed form to Benefits Office PRIOR to their return to work.

Provider Name: _____

Type of practice/area of specialization: _____

Date of Examination: _____ Date condition began: _____

Please check and complete one of the following:

Employee is able to work a full, regular schedule with no restrictions, beginning _____ (date)

Employee is unable to work from _____ (date) to _____ (date)

Employee is able to return to work on a reduced schedule for ____ hours per work day from _____ (date) through _____ (date)

Employee is able to return to work with restrictions from _____ (date) through _____ (date)

Please indicate restrictions, if any:

| | NEVER (up to 33%) | OCCASIONAL (34% to 66%) | FREQUENT (67% to 100%) | CONTINUOUS |
|------------------------------|----------------------|----------------------------|---------------------------|------------|
| Lift/carry: 0-25lbs. | | | | |
| 26-50lbs. | | | | |
| 50+lbs. | | | | |
| Push/pull | | | | |
| Reach above shoulder | | | | |
| Squat/kneel/stoop | | | | |
| Bending | | | | |
| Use of L/R hand for grasping | | | | |

Any other restrictions: _____

I certify that this certification accurately reflects my informed professional opinion regarding this individual's ability to return to work and perform tasks as indicated.

Provider Signature

Date

Please fax this form to Steph Monogue, UST Benefits, at 651.962.6524

University St. Thomas Benefits Office, 2115 Summit Avenue AQU217, St. Paul, MN 55105, 651.962.6519