FITNESS FOR DUTY CERTIFICATION TO RETURN FROM MEDICAL LEAVE

Teammate Name:_____ **Teammate ID:**_____
Last, First, Middle Initial (Please Print)

Teammate Date of Birth:_____/_____/_____

A teammate on a Medical Leave due to his/her own serious medical condition must present this release to HR Leave Administration **before** he/she returns to work. A teammate may not work without this release.

TO: Health Care Provider

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

1. Teammate Name: _____
2. Teammate's Job Title: _____
3. Date of Last Medical Examination: _____
4. Date Teammate May Return from Leave: _____
5. Please indicate with a checkmark, the status of the teammate's release for duty.

   _____ Full, unrestricted duty. (Skip question 6 and proceed to item 7.)

   _____ Modified duty. (Complete question 6 and 7.)

   _____ Not released for any type of duty. (Go to item 7.)

6. If you are releasing the teammate to modified duty, please complete the following:
   a. Estimated date that teammate will be able to return to full, unrestricted duty:_____.
   b. Date of your next medical evaluation of the teammate:_____.
   c. Indicate the exact work restrictions which apply to the teammate at this time using the chart on page 2 of this form.

Atrium Health has a Return to Work Program that provides our teammates with work restrictions the opportunity to return to work in a reduced capacity. Our program is designed to allow our teammate to safely perform modified or alternative work within their work restrictions while they recover. We promote an expeditious and productive return to work philosophy.

Is this teammate a candidate for the Return to Work Program? ☐ **Yes** ☐ **No**

Complete this section if the teammate is being released to modified duty.

☐ **None – Explain:** _____

☐ Return to work no greater than_____hours/day

☐ No lifting greater than_____pounds ☐ right ☐ left ☐ both

☐ No pushing/pulling greater than_____pounds ☐ right ☐ left ☐ both

☐ No reaching/working above shoulder ☐ right ☐ left ☐ both

☐ No work involving use of hand/arm ☐ right ☐ left ☐ both

☐ Sit down work only

☐ No walking/standing over_____minutes/hours

☐ No stooping ☐ No repeated bending ☐ No climbing ☐ No twisting, bending

Other: _____

_____

Additional Comments/Notes:

_____

_____

_____

_____

_____

_____

7. I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury at_____, this_____day of_____,_____.
(List City and State) (month) (year)

ATTENDING PROVIDER:

Print or Type Name:_____Signature:_____

Type of Practice/Medical Specialty: _____

Street Address:_____City / State:_____Zip Code: _____

Phone #:_____Fax #:_____Date _____

_____

_____

Providers can fax completed form to (704) 446-6624 or teammates can upload completed form in LeavePro. Call (704) 631-1500 with questions.