



# State of Colorado Fitness-To-Return Certification

**Instructions to Employee:** Return this form to your department/institution before or on the day you return to work.

Employee's Name	Employee ID #:
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**Instructions to Department/Institution:** Attach the job duty statements from the official Position Description Questionnaire (PDQ). 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.

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.

**Signature of Health Care Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Type of Practice** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_

**Email:** \_\_\_\_\_