PHYSICIAN'S FITNESS FOR DUTY RELEASE FORM

This information is confidential and will be used only in determining if this employee is capable of returning to work in the performance of the essential functions of their job in a safe manner.

Employee Name: ____

Social Security Number: ____

Employer: ____

After having reviewed the accompanying job description, this employee is released to return to work:
CIRCLE ONE:

Full Duty: with no restriction on (date) __________________

OR

Transitional Duty: with restrictions listed in the comments section on this form. This employee is released to work transitional duty with restrictions on (date)__________________

Date of expected full duty release ___________________

Comments:

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Physician's Signature ______________________________

Date __________________

Form 228 8-05