City of Melrose - FITNESS FOR DUTY CERTIFICATION

EMPLOYEE SECTION

Bring this form to every medical appointment. Return to Matt Travers, HR Dept. after your visit. This form is required before returning to work and for any medical benefits to be paid.

Employee Name_____

- ☐ Job related injury or illness
- ☐ Non-job related injury or illness
- ☐ Other_____

I hereby authorize you to release the information contained on this form to the City of Melrose and hereby release you (the health care provider) from any liability arising from such disclosure.

_____ _____

Employee's signature Date

Please digitally sign or print and sign

MEDICAL PROVIDER SECTION

This form must be completed by the healthcare provider, before the employee is allowed to resume job duties.

1. Employee Name:_____
2. Employee's Job Title: _____
3. Date of Medical Examination: _____
4. Date employee may return from leave: _____
5. Please indicate with a check mark the status of the employee's release for duty.

   _____ **Full, unrestricted duty** (*Skip question 6 and proceed to Table 1*)

   _____ **Modified duty** *(Complete question 6 and Table 1)*

   _____ **Not released for duty** *(Complete Table 1 and sign)*

6. If you are releasing the employee to modified duty, you must complete the following:
   a. Estimated date the employee will be able to return to full, unrestricted duty:

      _____

   b. Date of your next medical evaluation of the employee:

      _____

Please return to:
Matt Travers, HR Department
562 Main Street, Melrose, MA 02176
PHONE: 781-979-4170 FAX: 781-979-4246

c. Indicate the exact work restrictions the employee currently has on the table below:

TABLE 1.Using the employee's position description, please check the appropriate boxes.

PHYSICAL EXAMINATIONS	FULL RESTRICTIONS	PARTIAL RESTRICTIONS	NO RESTRICTIONS	DOES NOT APPLY
Sedentary- able to lift 0-10 lbs				
Light- able to lift 10-20 lbs				
Moderate- able to lift 20-50 lbs				
Heavy- able to life 50-100 lbs				
Pulling, Pushing & Carrying				
Reaching/working above shoulders				
Walking # of hours _____				
Standing # of hours _____				
Sitting # of hours _____				
Stooping				
Kneeling				
Repeated Bending _____times				
Climbing Stairs, ladders, hills				
Operating motor vehicle, tractor,etc				
Other				
Exposure Limitation (Specify):				

I hereby certify the foregoing facts are true and correct.

Signature of Health Care Provider
Please digitally sign or print and sign

Name of Health Care Provider

Date

Address

Telephone Number

Fax Number

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