City of Melrose - FITNESS FOR DUTY CERTIFICATION

Non-job related injury or illness

EMPLOYEE SECTION

Please bring this form to your medical appointment and return to Human Resources Dept. via Fax 781-979-4246 or hand delivery.
This form is required before returning to work.

Employee Name_____

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

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:

      _____

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

Please return to:
Human Resources
562 Main Street, Melrose, MA 02176
PHONE: 781-979-4146
Fax: 781-979-4246

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

Name of Health Care Provider

Date

Address

Telephone Number

Fax Number

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