

Fitness-for-Duty Certificate

Patient's Name

Date

On **, you certified that the patient had a serious health condition which made him/her unable to perform the essential functions of his/her job with the City of Menasha. Before we can return the patient to his/her job, you must certify that the patient is able to return to work and perform all of the essential functions of his/her job. Attached is a description of the patient's job and a list of all of the essential functions of his/her position. Please complete this form and return it to the patient as soon as possible. The patient will not be eligible to return to work without this completed form.

1. Is the patient currently able to perform the essential functions of his/her job without restrictions?
 Yes No

If "no", please identify each essential function(s) that the patient is not currently able to perform without restrictions:

2. Is the patient currently able to perform the essential functions of his/her job with restrictions?
 Yes No

If "yes", please describe all necessary restrictions:

3. If the patient is not currently able to perform the essential functions of his/her job, when, in your best medical opinion, will the patient be able to perform the essential functions of his/her job?

_____ (date)

Will the patient have work restrictions at that time? Yes No

If "yes", what will those restrictions be?

Will those restrictions be permanent? Yes No

If "no," what is their anticipated duration? _____

If "yes," please identify which restrictions are permanent:

4. After having examined the above patient on _____, is it your medical opinion that he/she is currently capable of returning to work without creating a significant risk (i.e., high probability) of substantial harm to the patient or his/her safety and/or the safety of the patient's co-workers or others? Yes No

If there is a significant risk, please identify the risk: _____

Further, can the risk be reduced or eliminated by reasonable accommodation?

Yes No

If yes, what reasonable accommodation(s) would be necessary to reduce or eliminate this risk?

Signature of Health Care Provider

Date

Printed Name of Health Care Provider

Type of Practice/Medical Specialty

Street Address

Telephone Number

City, State and ZIP Code

Facsimile Number