SYRACUSE
EST. CITY 1935

Fitness for Duty Certification

1. **Employee / Patient** _____

2. **Date of Medical Examination** _____

3. **Please check the status of the employee's release for duty**

   ☐ Full, unrestricted duty effective _____

   ☐ Modified duty effective _____ and next evaluation date _____

   ☐ Not released for any type of duty. Next evaluation date will be _____

4. **Physical Evaluation**

	Full Restrictions	Partial Restrictions (please specify)	No Restrictions
Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking			
Standing			
Stooping			
Kneeling			
Repeated Bending			
Climbing			
Operating a motor vehicle			
Finger Manipulation (typing)			
Pain (frequency, degree, signs)			

5. **Behavioral Evaluation**

	Not Able to perform	Other Considerations (please specify)	Able to perform
Understanding			
Remembering			
Sustained concentration			
Follow-through on instructions			
Decision making			
Receiving supervision			
Relating to co-workers and students			

6. **Other Restrictions, Considerations, or Notes**

_____

_____

I hereby certify that the facts in this document are true and correct.

_____ _____ _____

Printed Name of Health Care Provider Date Phone Number

_____

Signature of Health Care Provider

10/2022

Return to: sgreer@syracuseut.gov or fax 385-403-8479