State of Colorado Fitness-To-Return Certification

Instructions to Employee: Return this form to your department/institution before or on the day you return to work.

<table>
<thead>
<tr>
<th>Employee’s Name</th>
<th>Employee ID #:</th>
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Instructions to Department/Institution: Attach the job duty statements from the official Position Description Questionnaire (PDQ). This completed form is to be placed in a separate, confidential medical file with limited access.

Instructions to Health Care Provider: Please complete this form when the employee is seeking your release to return to work.

1. Date the condition began.

2(a) Check one of the following.
- The employee is able to work a full, regularly scheduled day with no restrictions beginning (date).
- The employee is unable to return for any work until _____ (date).
- The employee is able to return to work on a reduced schedule for _____ hours per day from _____ (date) through _____ (date).
- The employee is able to return to work with restrictions from _____ (date) through _____ (date).

   Please complete next section (b).

(b) Please indicate restrictions.
- no lifting or carrying objects: _____ max. lbs. Repetitions
- no pushing/pulling objects: _____ max. lbs. Repetitions
- no bending/stooping/squatting/twisting: Repetitions
- no kneeling for more than _____ hours each day
- no crawling for more than _____ hours each day
- no sitting for more than _____ hours each day
- no standing for more than _____ hours each day
- no walking for more than _____ hours each day
- no climbing stairs
- no working/climbing on elevated equipment (ladders, stools, roofs, poles, etc.) for more than _____ hours each day
- no reaching above the head or shoulders
- no reaching away from the body greater than ______ with □ right □ left arm
- no grasping objects with □ right □ left hand
- no fine manipulation with □ right □ left hand
- no assaultive, physical control, and/or arrest situations
- no driving a vehicle
- no operating machinery or equipment
- no working alone
- no use of firearms
- no typing, keyboarding, or entering data for more than _____ hours each day
- no use of a CRT or computer monitor for more than _____ hours each day
- no use, including repetitive, of _________ (extremity/joint)
- no weight bearing on _________ (extremity)
- Other restrictions (specify):

3. Other instructions:
Based on my personal evaluation of the patient’s condition, the above information is accurate and complete.

Signature of Health Care Provider _______________________________ Date __________________

Printed Name _______________________________ Type of Practice ________________

Address: ________________________________________________

Telephone: ( ) ____________________________ Fax: ( ) ____________________________

Email: ________________________________________________