20550 SOUTH CICERO AVENUE
MATTESON, IL 60443
TEL: 708/679-5800
FAX: 708/679-5733
WWW.RICH227.ORG

FITNESS FOR DUTY FORM

Employee:
Return completed form to employer prior to returning to work.

EMPLOYEE INFORMATION AND INFORMED CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION		
NAME:		
Address: City :	State:	ZIP:
Telephone Number:		

STATEMENT OF PHYSICIAN OR PRACTIONER	
Medical Facts Regarding Patients Condition:	
Date Condition Commenced:	Probable Duration of Condition:
Has patient reached the end of his or her healing period? _____YES _____NO	Is patient able to perform all of the functions of his/her regular job? _____YES _____NO
Please indicate restrictions if any:	
Is patient able to work his or her normal work schedule? If not please identify the number of hours per day and the number of hours per week that the patient can work, and the expected duration of the period for the reduced schedule.	
Is patient able to return to work without posing a significant risk or substantial harm to him/herself or others? _____YES _____NO	Date patient can return to work: If restrictions please list above.
Physician Signature:	Date:

PHYSICIAN OR PRACTITIONER INFORMATION	
Physician Name:	Specialty:
Address:	

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