

FITNESS FOR WORK

COMPANY NAME: _____

Company contact: _____ *Designated contact* Phone: _____ Fax: _____

_____ *Company Name* is committed to doing everything we can to achieve a successful recovery and return to work for our injured employees. Our Disability Management program is designed to help them return to work safely and at the earliest opportunity, using appropriate modified work alternatives when required.

We need your help! Please complete the fitness-for-work section at time of treatment and fax to the above number, or have our employee return it. A reporting fee of \$_____ will be paid.

Authorization to Release Information (to be completed by injured employee)

Injury: _____ Injury date: _____

I hereby authorize my treating health care provider to release information related to my fitness for work.

Employee's name: _____ Date: _____
(Print)

Employee's signature: _____

Fitness for Work (to be completed by treating health care provider)

Examination date: _____ Injury: _____

This worker is: not capable of any work How long? _____

fit for regular work, no restrictions

fit for modified work with the following recommendations:

Specific fitness recommendations and physical restrictions:

Sedentary Light Medium Heavy (see over for guidelines)

Estimated date fit for regular work: _____ Next appointment: _____

Health care provider's name: _____
(Please print)

Payment address: _____

Health care provider's signature: _____

WORK CAPABILITIES

Sedentary

- Lifting 10 lbs maximum
- Occasional lifting and/or carrying
- Primarily sitting with occasional walking/standing

Light

- Lifting 20 lbs maximum
- Frequent lifting and/or carrying up to 10 lbs
- May require walking/standing to a significant degree
- May involve sitting with pushing and pulling of arm and/or leg controls

Medium

- Lifting 50 lbs maximum
- Frequent lifting and/or carrying up to 20 lbs

Heavy

- Lifting 100 lbs maximum
- Frequent lifting and/or carrying up to 50 lbs