Fitness – For – Duty – Form

Employee's Name _____ Position_____

Directions: This form must be completed by your health care provider and returned to Azle ISD Benefits office at least 5 days prior to your return to work. The attached job description should be used by the provider to assess your ability to perform your job duties.

Fitness for Duty (to be completed by the health care provider)

Based on the employee's job and medical conditions:

___ the employee is able to return to work as of _____ (date) without restrictions.

___ the employee can return to work as of _____ (date) with the following restrictions, which are expected to last through _____ (date).

Restrictions listed below:

_____

_____

_____

_____

_____

_____

Signature if Provider: Date:

_____ _____

Name, Address, and Phone Number (please print)

_____

_____