FITNESS – FOR – DUTY CERTIFICATE

(Return-to-Work Certification)

Please return to
Human Resources
Chippewa Falls Area Unified School District
1130 Miles Street
Chippewa Falls, WI 54729
Phone: 715-738-2660 ext. 1901
Fax: 715-726-2781

_____ _____

Patient's Name *Date*

On _____, you certified that the patient had a serious health condition which made him/her unable to perform the essential functions of his/her job with the Chippewa Falls Area Unified School district. Before we can return the patient to his/her job, you must certify that the patient is able to return to work and perform all of the essential functions of his/her job. Please complete this form and return it to the patient as soon as possible. ***This patient will not be eligible to return to work without this completed form.*** *Your patient may return to work on:* _____

1. *Is this patient currently able to perform the essential functions of his/her job without restrictions?*

   ☐ *Yes* ☐ *No*

   If "no", please identify each essential function(s) that the patient is not currently able to perform without restrictions.

   _____
   _____
   _____
   _____
   _____

2. *Is the patient currently able to perform the essential functions of his/her job with restrictions?*

   ☐ *Yes* ☐ *No* *If "yes", please describe all necessary restrictions.*

   _____
   _____
   _____
   _____

   Are these restrictions permanent? ☐ *Yes* ☐ *No*
   If "no", what is their anticipated duration? _____

   If "yes", please identify which restrictions are permanent:

_____
_____
_____

3. *If the patient is not currently able to perform the essential functions of his/her job, when, in your best medical opinion, will the patient be able to perform the essential functions of his/her job?*

_____

Will the patient have work restrictions at that time? ☐ *Yes* ☐ *No*

If "yes", what will those restrictions be?

_____
_____

Will those restrictions be permanent? ☐ *Yes* ☐ *No*
If "no", what is their anticipated durations? _____

If "yes", please identify which restrictions are permanent: _____
_____
_____

4. *After having examined the above patient on _____, is it your medical opinion that he/she is currently capable of returning to work without creating a significant risk (i.e., high probability) of substantial harm to the patient or his/her safety and/or the safety of the patient's co-workers?* ☐ *Yes* ☐ *No*

If there is a significant risk, please identify the risk: _____
_____
_____

Further, can the risk be reduced or eliminated by reasonable accommodation?

☐ *Yes* ☐ *No*

If "yes", what reasonable accommodation(s) would be necessary to reduce or eliminate this risk?
_____
_____

_____ _____
Signature of Health Care Provider *Type of Practice/ Medical Specialty*

_____
Printed Name of Health Care Provider

_____ _____
Street Address *Telephone Number*

_____ _____
City, State and Zip Code *Fax Number*