Return to Work / Fitness for Duty Certification

You and your Health Care Provider must complete this form and submit it to the Athletico Leave Department at Leaves@Athletico.com or via fax at 630.928.3429. Please provide at least two (2) business days prior to your return-to-work. You must notify your manager **and** the Athletico Leave Department of your expected return date prior to your return. Send an email to Leaves@Athletico.com confirming your expected return date.

Patient Name (Employee): ___________________________________**Employee ID:** ____________________________________

☐ May return-to-duty **WITHOUT** restrictions on ______ / ______ / ______

☐ Able to work **WITH** restrictions specified below from ______ / ______ / ______ through ______ / ______ / ______ (***end date required****)

*If a definitive end date cannot be determined at this time, please specify date of next re-evaluation: ______ / ______ / ______

☐ Has **NOT** been disabled from work while under my care or treatment

Employee can work:

☐ their regular scheduled work day (*at least 8 hours per day*)

☐ no more than _____ hours/day; ______ hours/week

☐ other (specify any other schedule):

____

____

Only indicate work restrictions resulting from the medical condition that caused the need for the leave of absence or workplace accommodation. In compliance with the Genetic Information Nondiscrimination Act of 2008 (GINA), do **NOT** provide any genetic information when completing this form.

Employee able to	**without any restrictions**	***with restrictions**	**cannot perform**	***Explain any accommodation or restrictions, such as specific lifting or weight bearing limitations, assisted devices, etc.**
Stand	________	________	________	____
Sit	________	________	________	____
Walk	________	________	________	____
Run / Jog	________	________	________	____
Bend	________	________	________	____
Squat/crouch	________	________	________	____
Climb	________	________	________	____
Reach	________	________	________	____
Grasp	________	________	________	____
Type / 10 key / data entry	________	________	________	____
Lift or carry	________	________	________	____
Push or pull	________	________	________	____
Weight bearing	________	________	________	____
Fine hand manipulation	________	________	________	____
Drive a vehicle	________	________	________	____
Work independently	________	________	________	____
Operate equipment/machinery	________	________	________	____

Does employee have any environmental restrictions such as noise, extreme temperature? ___ yes ___ no (If yes, specify below)
Have you prescribed medication that could impair the employee's judgment or motor coordination? ___ yes ___ no (If yes, specify below)

Please explain any work restrictions or accommodations that need clarification or have not been addressed above and the duration of these restrictions/accommodations: ____

____

____

____

Physician's Name____ **Signature** _____________________________ **Date**_____________________

Physician Phone/Fax/Address____

I authorize and request any physician, medical practitioner, or other provider of health services who has assessed or treated my current medical condition to furnish the information requested above to my employer, Athletico.

Patient/Employee Signature ____ **Date** _____________________

Return form to: Athletico Leave Department **|** *Fax: 630.928.3429* **|** *Email: Leaves@athletico.com* **|** *2122 York Road, Suite 300, Oak Brook, IL 60523*