City of Waterbury and Board of Education
EMPLOYEE FITNESS FOR DUTY CERTIFICATION

Part A. – To be completed by Employee

To Employee: You must present this release to be completed by a licensed healthcare provider at your time of visit and return to your human resources representative within three (3) days of your visit.

Employee's Name: _____

Employee's Position: _____

Department/School: _____

Supervisor: _____

Date Leave Commenced: _____

I, the undersigned, understand that following my medical leave under the federal FMLA and/or Connecticut General Statute 5-248a my restoration to employment with the City or District is subject to the following conditions:

1. As a condition of employment, I must provide written certification from my health care provider certifying that I am able to resume work.
2. Upon the expiration of any such leave of absence, I will be entitled (A) to return to my original position from which the leave of absence was provided or, if not available, to an equivalent position with equivalent pay, except that in the case of a medical leave, if I am medically unable to perform the duties of my position upon the expiration of such leave, the City of Waterbury Human Resources Department and Waterbury Public Schools Personnel Department in conjunction will endeavor to find other suitable work for me in City service, and (B) to all accumulated seniority, retirement, fringe benefit and other service credits I had at the commencement of such leave.
3. Such service credits will not accrue during any unpaid period of the leave of absence, except as otherwise provided by contract.

Employee's Name: _____

Employee's Signature: _____ Date: _____

Part B. To be completed by the Attending Physician or Medical Provider

The City of Waterbury and Waterbury Public Schools **have** implemented a Return-to-Work Program in an effort to assist our employees in returning to suitable employment while they recuperate from illness or injury. If the employee is unable to immediately return to work, we will make every effort to assign them to transitional duty, within the employee's physical capabilities. Included with this form is the Employee's job description along with essential physical functions. Please provide the release date for regular duty and/or indicate physical restrictions below. Thank you.

Employee Name: _____ **Position**: _____

Date of Injury-or Onset of Illness: _____

Office Visit: Date: _____ Time In: _____ Time Out: _____

(1) The Employee's return-to-work status is:

- ☐ Return to regular work: Date: _____
- ☐ Able to return to work with noted restrictions: Date: _____
- ☐ Unable to return to work until next evaluation: Date: _____
- ☐ Referred to another health care provider: Name: _____
  Date: _____

(2) Employee may work full-time hours?

- ☐ Yes
- ☐ No

If NO: Maximum Hours/Workday: _____ Maximum Hours/Week: _____

(3) **Lifting/Carrying Restrictions:**

- ☐ 40-50 lbs.
- ☐ 30-39 lbs.
- ☐ 20-29 lbs.
- ☐ 10-19 lbs.
- ☐ 5-9 lbs.
- ☐ Less than 5 lbs.
- ☐ No Restrictions

(4) **Restrictions Include:**

Employee can perform them:

	Not at all	Occasionally	Frequently
☐ Alternate sitting and standing every ___ hours			
☐ Balancing			
☐ Bending (forward)(backward)			
☐ Climbing (stairs)(ladders)			
☐ Crawling			
☐ Driving vehicle, truck, dump truck			
☐ Exposure to chemicals, solvents, etc.			
☐ Exposure to gases and fumes			
☐ Exposure to high humidity			
☐ Exposure to loud noises or vibration			
☐ Exposure to temperature extremes			
☐ Fine motor skills e.g., keyboarding			
☐ Grasping			
☐ Kneeling			
☐ Lifting above shoulders			
☐ Lifting from below knees			
☐ Operating heavy/mechanical equipment			
☐ Physical intervention			
☐ Pushing/pulling			
☐ Reaching above shoulders			
☐ Repetitive feet motion			
☐ Repetitive wrist motion			
☐ Restraining			
☐ Sitting			
☐ Squatting			
☐ Standing			
☐ Stooping			
☐ Transferring (wheelchairs, standers, tables, toilets, etc.)			
☐ Twisting			
☐ Under medication that could affect ability to work			
☐ Walking			

(5) Is the ability to perform professional responsibilities affected because of a neuropsychiatric condition (e.g., ability to give/take supervision, meet deadlines, follow rules/directions, etc.?

☐ No

☐ Yes. If yes, describe: _____

(6) Other restrictions or limitations. Please explain:

_____

_____

_____

_____

I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury at _____, this _____ day of _____, ____
(List City and State) (month) (year)

_____ _____
Signature of Health Care Provider Date

_____ _____
Print Name of Health Care Provider Phone Number

_____ _____
Type of Practice License No.

_____
Street Address

_____
City State Zip

cc: Personnel File