



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT FITNESS FOR DUTY

Non-work related injury or illness

Workers' Compensation

*Note to Supervisor and Employee:* Employee is not allowed back on the job site until this form has been reviewed and approved for return to work. Human Resources will contact the supervisor to facilitate the review and approval process. **Fax this form to (907) 451-6008 or hand-deliver form to Human Resources.**

*Note to Supervisor and Employee:* Treating employee is not allowed back to duty until Risk Management has reviewed and approved their return to work. The Claims Adjuster will contact the supervisor to facilitate the review and approval process. **Fax completed form to (907) 459-1187 or hand deliver to FNSB Risk Management within one day of your appointment.**

## Employee Work Status (Fitness for Duty)

**Employee Name:** \_\_\_\_\_

- Unable** to return to work until \_\_\_\_\_
- Can return to **full work** with no restrictions on: \_\_\_\_\_ (Please mark restrictions below)
- Can return to **modified work** on: \_\_\_\_\_ adhering to **restrictions** checked below:

### Physical Capacity Restrictions

**All sections must be completed by treating physician**

NOTE: **OCCASIONALLY** (UP TO 2 HOURS PER 8-HOUR DAY) **FREQUENTLY** (UP TO 4 HOURS PER 8-HOUR DAY)

Lift/Carry	Not At All	Occasionally	Frequently	No Restrictions
0 – 3 lbs.	_____	_____	_____	_____
4 - 10 lbs.	_____	_____	_____	_____
11 - 20 lbs.	_____	_____	_____	_____
21 - 40 lbs.	_____	_____	_____	_____
Over 40 lbs.	_____	_____	_____	_____
<b>Able To Do</b>				
Bending	_____	_____	_____	_____
Squatting	_____	_____	_____	_____
Climbing	_____	_____	_____	_____
Pushing/Pulling	_____	_____	_____	_____
Kneeling	_____	_____	_____	_____
Reach above shoulder	_____	_____	_____	_____
Repetitive hand motion	_____	_____	_____	_____
Stand	_____	_____	_____	_____
Walk	_____	_____	_____	_____
Sit	_____	_____	_____	_____
Drive	_____	_____	_____	_____

- \_\_\_\_\_ Keep wound/dressing clean & dry
- \_\_\_\_\_ Use assistive devices: sling, brace, crutches
- \_\_\_\_\_ Avoid contact with chemicals
- \_\_\_\_\_ can do data entry \_\_\_\_\_ hours at a time
- Other \_\_\_\_\_

Describe how any prescribed medications would adversely affect the performance of essential job functions:

\_\_\_\_\_

#### Follow-Up Care

- \_\_\_\_\_ Final visit, discharge from care for this injury/illness
- Re-Evaluation on \_\_\_\_\_
- \_\_\_\_\_ Physical Therapy prescribed: Frequency \_\_\_\_\_
- Duration \_\_\_\_\_

Comments: \_\_\_\_\_

Physician Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Human Resources' Signature: \_\_\_\_\_ Date: \_\_\_\_\_