FITNESS-FOR-DUTY TO RETURN FROM LEAVE CERTIFICATION

To: County of Santa Barbara Employee:

You must present this release to your supervisor before or on the day you return to work. You may not work without this release

To: Treating Physician or Practitioner

Our employee began a period of medical care leave for his/her serious health condition on _____

(date employee commenced leave)

As a condition of returning to work, the employee must take a physical examination and have his/her physician complete this form. This form must be completed before the employee is allowed to resume his/her job duties.

1. **Employee Name:**

_____

2. **Employee's Job Title:**

_____

3. **Date of "Return-to-Work" Physical Examination:**

_____

4. With respect to your understanding as to what are the employee's essential job functions, please check the source(s) where you received your information:
   - _____ County job description
   - _____ Discussion with the employee's supervisor
   - _____ Discussion with the employee
   - _____ Other. Please explain:_____

5. Please indicate the status of the employee's release for duty.

_____ Fully, unrestricted duty. Please skip question 6 and proceed to question 7.

_____ Modified duty. You must complete question 6.

____ Not released for any type of duty.

6. If you are releasing the employee to modified work duty, you must complete this section thoroughly.

a. Estimated date that employee will be able to return to full, unrestricted duty: _____

b. Date of your next evaluation of the employee: _____

Indicate the exact work restrictions which apply to the employee at this time on the chart below.

PHYSICAL LIMITATIONS	FULL RESTRICTIONS	PARTIAL RESTRICTIONS	NO RESTRICTIONS
Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs.)			
Standing (hrs.)			
Sitting (hrs.)			
Stooping (hrs.)			
Kneeling (hrs.)			
Repeated Bending (hrs.)			
Climbing (hrs.)			
Operating a motor vehicle, crane, tractor, etc.			
Other:			
Exposure Limitation (Specify):			

7. I hereby certify that the foregoing facts are true and correct, and are executed under penalty of perjury in _____, California this _____ day of_____, 20____.

_____

Signature of Treating Physician or Practitioner Date

_____

Print Name of Treating Physician or Practitioner Phone Number