

# CITY OF POMONA

## FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION

**To City of Pomona 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:

The 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 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:
  - City job description
  - Discussion with 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: \_\_\_\_\_.
  - c. Indicate the exact work restrictions which apply to the employee at this time on the chart below:

<b>PHYSICAL LIMITATIONS</b>	<b>FULL RESTRICTIONS</b>	<b>PARTIAL RESTRICTIONS</b>	<b>NO RESTRICTIONS</b>
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