# Fitness for Duty/Return to Work Form

*Medical authorization from attending physician is required for employees returning to work from family and medical leave. This form must be returned to Human Resources prior to or before returning to work.*

## ***Employee Section***

Employee Name/Patient: (Last, First) _____

CWID: _____ Date of Injury/Illness: _____ /_____ /_____

## ***Physician Section***

☐ May resume work at full duty, **without** restrictions, effective date: _____ /____ /_____

☐ Normal shift, regular duties

☐ May resume work **with** the following restrictions, effective date: _____ /____ /_____

Expected duration of accommodations is: _____

☐ Full Time **OR** ☐ Part-Time @ _____# hours /per day or _____ /per week

☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 lbs.)

☐ Light work (lifting less than 20 lbs.)

☐ Medium work (lifting less than 50 lbs.)

☐ Heavy work (lifting less than 100 lbs.)

☐ Other – Please describe: _____

_____

_____

He / She has a return appointment on (date) _____ /____ /_____ at (time) _____.

_____ _____

Physician Name (print) Physician Signature Date

_____

Phone Number (include area code) Street Address, City, State and Zip Code

Collin College, Human Resources Department, Collin Higher Education Center
3452 Spur 399, McKinney, TX 75069 - Benefits@Collin.edu - Office (972) 599-3152 - Fax (972) 599-3156

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