Fitness for Duty Clearance

Date: _____

Employee Name: _____

Position/Title: _____

Department: _____

Medical Evaluation

Based on my evaluation, the above-named employee is:

- ☐ Fit for Duty
- ☐ Fit for Duty with Restrictions
- ☐ Not Fit for Duty

If restrictions apply, describe:

_____

Physician/Healthcare Provider Information

Name: _____

Signature: _____

Date: _____

Employer Use Only

Reviewed by: _____

Date: _____