Fitness for Duty Assessment
RETURN TO WORK EVALUATION FORM

Summit Healthcare
Human Resources

Summit Healthcare will use the information provided by the employee's physician to help in determining the patient's work status. Thoughtful consideration in completing this form will, therefore, be greatly appreciated.

Today's Date:	
Employee Name:	
Date of Injury/Illness or Condition:	

CARE PROVIDED:

☐ **Surgical**

☐ **Interventional Treatment**

☐ **Physical Therapy – Frequency/Duration**

_____

☐ **Other**

_____

☐ **Medication:**

Please list medications associated with this event that could have a negative effect on their physical or mental abilities to perform the duties of the attached job description.

_____

_____

_____

☐ **Avoid Driving or Operating Machinery While Using This Medication.**

ASSESSMENT OF PATIENT ABILITY TO PERFORM CURRENT JOB:

Attached is a copy of the Job Description for this position.

Can the patient currently be reasonably expected to perform the listed activities without being placed at risk or create patient risk due to their medical or physical condition?
Please initial applicable response(s) and provide appropriate comments.

_____YES, the employee can perform the current job duties without any restrictions.

_____YES, if the following conditions listed below can be met:
Please list the conditions:

_____

_____

_____

_____NO, the employee cannot currently be reasonably expected to perform the listed activities without being placed at risk.
Please indicate reason(s) and explain:

_____

_____

_____

_____

If you answered "No" to the previous question, do you expect a fundamental or marked change in the future?
Please initial appropriate response(s) and provide appropriate comments.

_____NO. If "no" please explain

_____

_____

_____YES.
If "yes" please indicate when you feel the patient will recover sufficiently to perform duties

_____

_____

_____

WORK STATUS:

☐ **Return to regular work on (please specify date):**

_____

☐ **Unable to work until (please specify date):**

_____

☐ **Return to transitional duty on :__for ____days with the restrictions noted above.**

FOLLOW-UP CARE:

☐ **Estimated length of treatment:**

☐ Days ☐ Weeks ☐ Months

_____

☐ **Scheduled for physician appointment on date:**

_____

☐ **Scheduled for physical therapy on date:**

_____

☐ **Referral:**

_____

☐ **Discharged from care, stationary, with _____% impairment of**

_____

SIGNATURE

Thank you for your assistance. If you have any questions, please contact Connie Kakavas, Chief Human Resources Officer, (928) 537-6366

Physician Name:

_____

(Please Print or Type)

Physician Signature: _____

Address:

_____

_____

Phone number:

_____

Facsimile number:

_____