COUNTY OF MARIN
DEPARTMENT OF HUMAN RESOURCES
Our Mission: To create a thriving organization, providing meaningful careers in public service.

County of Marin

Fitness for Duty to Return from Leave Certification Form

Human Resources Department
PMR 44 – Leaves of Absence

For: _____ _____
Employee name Department/Division

NOTE: 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 _____

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.

   - ☐ County job specification/job analysis
   - ☐ 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 7.
   - ○ Modified duty. You must complete question 6.
   - ○ Not released for any type of duty. You must complete question 6. A & B.

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 following chart:

Physical Limitations	Full Restrictions	Partial Restrictions	No Restrictions
Sedentary lifting 0 – 10 pounds	☐	☐	☐
Light lifting 10 – 20 pounds	☐	☐	☐
Moderate lifting 20 – 50 pounds	☐	☐	☐
Heavy lifting 50 – 100 pounds	☐	☐	☐
Pulling/pushing, carrying	☐	☐	☐
Reaching or working above shoulder	☐	☐	☐
Walking (hours)	☐	☐	☐
Standing (hours)	☐	☐	☐
Sitting (hours)	☐	☐	☐
Stooping (hours)	☐	☐	☐
Kneeling (hours)	☐	☐	☐
Repeated bending (hours)	☐	☐	☐
Climbing (hours)	☐	☐	☐
Operating a motor vehicle, crane, tractor, etc.	☐	☐	☐
Exposure limitation (Specify)	☐	☐	☐
Other:	☐	☐	☐

7. I hereby certify that the foregoing facts are true and correct and are executed under penalty of perjury in ☐ , California.

_____ ☐
Signature of treating physician or practitioner — Date

_____ ☐
Print name of treating physician or practitioner — Phone number