FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT
FITNESS FOR DUTY

Non-work related injury or illness

Note to Supervisor and Employee: Employee is not allowed back on the job site until this form has been reviewed and approved for return to work. Human Resources will contact the supervisor to facilitate the review and approval process. Fax this form to (907) 451-6008 or hand-deliver form to Human Resources.

Workers’ Compensation

Note to Supervisor and Employee: Treating employee is not allowed back to duty until Risk Management has reviewed and approved their return to work. The Claims Adjuster will contact the supervisor to facilitate the review and approval process. Fax completed form to (907) 459-1187 or hand deliver to FNSB Risk Management within one day of your appointment.

Employee Work Status (Fitness for Duty)

Employee Name:

☐ Unable to return to work until ____________________________ (Please mark restrictions below)
☐ Can return to full work with no restrictions on: ____________________________
☐ Can return to modified work on: ____________________________ adhering to restrictions checked below:

Physical Capacity Restrictions

All sections must be completed by treating physician

NOTE: OCCASIONALLY (UP TO 2 HOURS PER 8-HOUR DAY) FREQUENTLY (UP TO 4 HOURS PER 8-HOUR DAY)

<table>
<thead>
<tr>
<th>Lift/Carry</th>
<th>Not At All</th>
<th>Occasionally</th>
<th>Frequently</th>
<th>No Restrictions</th>
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<tbody>
<tr>
<td>0 – 3 lbs.</td>
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<td>4 - 10 lbs.</td>
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<tr>
<td>11 - 20 lbs.</td>
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<td>21 - 40 lbs.</td>
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<tr>
<td>Over 40 lbs.</td>
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Able To Do

Bending
Squatting
Climbing
Pushing/Pulling
Kneeling
Reach above shoulder
Repetitive hand motion
Stand
Walk
Sit
Drive

☐ Keep wound/dressing clean & dry
☐ Use assistive devices: sling, brace, crutches
☐ Avoid contact with chemicals
☐ can do data entry _______ hours at a time

Other

Describe how any prescribed medications would adversely affect the performance of essential job functions:

Follow-Up Care

☐ Final visit, discharge from care for this injury/illness

☐ Re-Evaluation on ____________________________

☐ Physical Therapy prescribed: Frequency ____________________________ Duration ____________________________

Comments:

Physician Printed Name: ______________ Date: ______________
Physician Signature: ______________ Date: ______________
Human Resources’ Signature: ______________ Date: ______________

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