EASTERN MICHIGAN UNIVERSITY™

Certification of Health Care Provider Addendum

Fitness for Duty Report

RETURN TO WORK PLAN. Please specify restrictions as needed.

Employee Name ____

☐ Return to work Unrestricted on Effective Date ______________________

☐ Return to work Restricted on Effective Date ______________________

Expiration Date ______________________

Target Date for Full Recovery __________________

Has the employee reached Maximum Medical Improvement (MMI)? ☐ Yes ☐ No

Target Date for MMI ________________________

LIFTING LIMIT OF __________________ POUNDS

Limit work about chest/shoulder level with R L Upper Extremity
☐ None ☐ Limited to______

Forceful or Repetitive Grasping with R L Hand
☐ None ☐ Limited to______

Bending or Twisting at Waist
☐ None ☐ Limited to______

Kneeling/Squatting
☐ None ☐ Limited to_____

Walking
☐ None ☐ Limited to______

☐ Sit or Stand at Will
☐ Other ____________________
____

Limit Hours of Work to______________

Additional Comments: ____
____
____

HEALTH CARE PROVIDER INFORMATION.

Health Care Provider Name (please print)		Specialty
Health Care Provider's Address	Telephone Number	Fax Number
Health Care Provider's Signature ______________________		Date Signed ______________

Form # HRLOA 6 Date Revised : 12/05/05