ROBINS & MORTON

Medical Clearance for Duty - Jobsite

Date: ____________ Employee Name: ________________________________ Social Security Number: ________________

Position: ______________________________ Shift Schedule: __________ Hours per Day / ______ Days per Week ________

Employee's Physician: ______________________________ Address: ____

Office Telephone: ________________________________ Office Fax: ____

☐ I certify this illness/injury is non-work related.

Employee Authorization

Injury / Illness: ____

Prescribed Medications: ____

☐ I authorize my employer to seek a medical clearance for duty from my physician and authorize my physician to release the information requested.

☐ I **DO NOT** authorize my employer to seek a medical clearance for duty from my physician and I DO NOT authorize my physician to release the information requested.

Employee Signature: ____ Date: ______________________________________

Dear Physician:

The employee listed above has identified you as his/her treating physician for a personal injury or illness. In order to ensure the safety of this worker, we are asking that you evaluate both the employee's physical or psychological status and the potential effects of any medications the employee has been prescribed and determine if this person can safely perform their full duty assignments. In order to assist you in your assessment, we have provided below the physical requirements of the job and as well as any additional information deemed appropriate. We do not request personal medical information, only your professional opinion as to the employee's ability to safely perform their duties.

Physical requirements / Work Environment:

- The work environment is construction sites
- Outdoor, unconditioned ambient temperatures
- This position is a two-handed operation
- Individual must have good eye/hand coordination and vision must be adequate to perform duties
- The position requires employees to lift up to 50 pounds
- May be required to work in confined spaces
- Must be able to perform work at heights
- Compare and see differences in the size, shape and form of lines, figures and objects
- Frequent kneeling, crawling, climbing and continuous balancing, reaching forward and overhead and pushing/pulling, twisting, bending, lifting, carrying, squatting, sitting, standing, and walking

Additional Information: ____

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Physician's Assessment

I have evaluated the employee's condition, the prescribed treatment, the provided physical requirements and the work environment. Based on my evaluation, the employee:

☐ **IS ABLE** to safely perform their full duties as prescribed on the document

☐ **IS NOT** able to safely perform their full duties as prescribed on this document

Additional Comments:____

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Date: ________________ Physician's Signature: ____________________ Physician's License Number: ________________

After completing this form please fax to __________________. If you have any question, please contact ______________________.