ROBINS & MORTON

Medical Clearance for Duty – Office

Please complete this form and return it promptly to the Human Resources department. Robins & Morton reserves the right to have you seen by a doctor selected by the Company at no cost to you.

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. _____ (*initials)*

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:

- Ability to perform repetitive movements.
- Ability to work overhead.
- Ability to use hands to grasp.
- Ability to stand, walk, stoop, kneel, squat, crawl, and twist.
- Ability to sit, climb and balance.
- Ability to frequently lift and/or push or pull up to 25 pounds and occasionally lift and/or push or pull up to 50 pounds.
- Ability to work in an office environment over the hours of 8am to 5pm, Monday through Friday.

Additional Information: _____

_____

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: _____

_____

Date: _____ Physician's Signature: _____ Physician's License Number: _____