Bonner County
Return to Work Form
Fitness for Duty

Fax, Scan or Mail to:
Human Resources
1500 HWY 2 #337
Sandpoint, ID 83864
HR@bonnercountyid.gov
Fax:208-265-1456

EMPLOYEE:_______________________________________ LAST EXAM DATE: ________/_______/_________

Date of Injury/Illness/Surgery: ___________________________ NEXT EXAM DATE: _______/_______/__________

Employee's regular job title: _____________________________ Department: ______________________________

The above-named employee is under my care. I release him/her to return to work as specified below:

☐ **FULL DUTY,** usual job, no restrictions, as of: ____________________________ (date.)

☐ **Transitional Work -** with the **following Work Restrictions/Capacities,** as of ___________ (date), to be adhered to at work **until their next appointment on** ________________ (date).

☐ Work FULL-TIME; ☐ Work PART-TIME only: ______hours per day, _______ days per week

Employee can safely perform these functions: (*please check below*)

Lift /Carry	No restriction	Up to 5 lbs	10 lbs	25 lbs	50 lbs	Not at all
Push /Pull	No restriction	Up to 5 lbs	10 lbs	25 lbs	50 lbs	Not at all
Stand/walk			No restriction	Frequently	Occasionally	Not at all
Stoop/Bend at Waist			No restriction	Frequently	Occasionally	Not at all
Kneel/Squat			No restriction	Frequently	Occasionally	Not at all
Climb			No restriction	Frequently	Occasionally	Not at all
Sit			No restriction	Frequently	Occasionally	Not at all
Other			No restriction	Frequently	Occasionally	Not at all
Reach Above Shoulder with Left arm/right Arm *(circle one or both)*			No restriction	Frequently	Occasionally	Not at all
Repetitive use of Left hand/ right hand *(circle one or both)*			No restriction	Frequently	Occasionally	Not at all
Keyboard/mouse			No restriction	Frequently	Occasionally	Not at all
Drive (to work / while at work *(Circle one or both.)*			No restriction	Frequently	Occasionally	Not at all

Comments:____

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☐ **OFF WORK** because of **Medical Necessity** due to: ☐ Hospitalization; ☐ bed rest; ☐ work or commute is medically contraindicated (will worsen condition or delay recovery)

Explain (please do not include medical diagnosis)**:** ____

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Estimated date Employee may be released: ☐ Transitional Work ☐ Full Duty on date:____________________

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Healthcare Provider (Signature) **Date**_______/__________/___________