PHYSICAL CONDITION AND RESTRICTIONS REPORT

Employee: _____ Position: _____ CDL: ☐ Yes ☐ No

Department: _____ Employee number: _____

Date of Injury/Illness: _____ Date of Return to Work: _____

(Examining Physician to complete the following section)

Indicate Employee's Fitness for Duty: As of _____(Date)

☐ Fit for Full Duty ☐ Fit for Restricted duty ☐ Totally Disabled

Physical Restrictions:	**Unrestricted**	**Restricted**	
Ability to Walk	☐	☐	Explain: _____
Ability to Stand	☐	☐	Explain: _____
Ability to Operate Vehicle	☐	☐	Explain: _____
Ability to Operate Commercial Motor vehicle (over 26,00 LBS) in accordance with DOT	☐	☐	Explain: _____
Ability to Work Outdoors	☐	☐	Explain: _____
Ability to Bend Body	☐	☐	Explain: _____
Ability to Crouch	☐	☐	Explain: _____
Ability to Climb Stairs	☐	☐	Explain: _____
Ability to Lift (Indicate any LBS restrictions)	☐	☐	Explain: _____
Other	☐	☐	Explain: _____

Is the employee currently taking any medication that may impair his/her judgement, or the ability to drive or perform their duties (as outlined on the attached job description): ☐ Yes ☐ No

If Yes, explain: _____

Able to write/type: ☐ Yes ☐ No Able to Use Phone: ☐ Yes ☐ No

Physician: _____ Signature: _____ Date: _____

Revised June 2021