Fitness for Duty Assessment
RETURN TO WORK EVALUATION FORM

City of Scottsdale
Human Resources

The City of Scottsdale will use the information provided by the employee's physician to help in determining the patient's work status. Thoughtful consideration in completing this form will, therefore, be greatly appreciated.

Today's Date:	
Employee Name:	
Social Security Number:	
Date of Injury/Illness or Condition:	
Diagnosis	
Nature and Extent of Illness/Condition or Injury: (Please attach any continuation page(s) necessary to provide narrative of past medical history and current medical condition.)	
Current Medical Status of the above referenced Illness/Condition, or Injury. (Please include diagnosis and prognosis here.)	

CARE PROVIDED:

☐ **Physical Exam**

☐ **X-Ray**

☐ **Physical Therapy – Frequency/Duration**

_____

☐ **Other**

_____

☐ **Medication:**

Please list medications currently prescribed for the patient, their purpose, the how long (time period) the patient will need to take the medication, and the affect the medication could have on their physical or mental abilities to perform the duties of the attached job description.

_____

_____

_____

☐ **Avoid Driving or Operating Machinery While Using This Medication**

ASSESSMENT OF PATIENT ABILITY TO PERFORM CURRENT JOB:

Attached is a copy of the Job Description for this position.

Can the patient currently be reasonably expected to perform the listed activities without being placed at some risk due to their medical or physical condition?
Please initial applicable response(s) and provide appropriate comments.

_____**YES, the employee can perform the current job duties without any restrictions.**

_____**YES, if the following conditions listed below can be met:**
Please list the conditions:

_____

_____

_____

_____**NO, the employee cannot currently be reasonably expected to perform the listed activities without being placed at risk.**
Please indicate reason(s) and explain:

_____

_____

_____

_____

If you answered "No" to the previous question, do you expect a fundamental or marked change in the future?
Please initial appropriate response(s) and provide appropriate comments.

_____**NO.** If "no" please explain

_____

_____

_____**YES.**
If "yes" please indicate when you feel the patient will recover sufficiently to perform duties

_____

_____

_____

WORK STATUS:

☐ **Return to regular work on (please specify date):**

_____

☐ **Unable to work until (please specify date):**

_____

☐ **Return to transitional duty on :**_____ **for** _____ **days with the restrictions noted above.**

FOLLOW-UP CARE:

☐ **Estimated length of treatment:**

☐ Days ☐ Weeks ☐ Months

☐ **Scheduled for physician appointment on date:**

☐ **Scheduled for physical therapy on date:**

☐ **Referral:**

☐ **Discharged from care, stationary, with _____% impairment of**

SIGNATURE

Thank you for your assistance. If you have any questions, please contact the designated Human Resources Analyst at (480) 312-2491.

Physician Name:

(Please Print or Type)

Physician Signature:

Address:

Phone number:

Facsimile number: