OCCUPATIONAL HEALTH CLINIC: [Clinic Name]

DATE: [Date of Evaluation]

TO: [Employer Name / HR Department]
ATTENTION: [Contact Person Name]

RE: FITNESS FOR DUTY EVALUATION

Employee Name: [Employee Full Name]
Employee ID/DOB: [ID Number or Date of Birth]
Job Title: [Position Title]

Dear [Contact Person Name],

A Fitness for Duty evaluation was performed on the above-named employee on [Date]. Based on the clinical findings and the requirements of the job description provided, the following status has been determined:

STATUS:

- [ ] **Fit for Duty:** The employee may return to full, unrestricted duty effective [Date].
- [ ] **Fit for Duty with Restrictions:** The employee may work with the following limitations from [Start Date] to [End Date]:
    - [List restriction 1, e.g., No lifting over 10 lbs]
    - [List restriction 2, e.g., No prolonged standing]
    - [List restriction 3, e.g., Sedentary work only]
- [ ] **Not Fit for Duty:** The employee is currently unable to perform the essential functions of their position. A follow-up evaluation is scheduled for [Follow-up Date].

Notes/Comments:
[Additional non-confidential comments regarding work capacity]

This evaluation is based solely on the employee's functional ability to perform job-related tasks safely. No private medical diagnosis is contained herein in accordance with privacy regulations.

Sincerely,

[Provider Signature]
[Provider Name, Title]
[Clinic Phone Number]