CITY OF FORT DODGE
HUMAN RESOURCES

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EMPLOYER-PHYSICIAN COMMUNICATION FORM
LIGHT DUTY WORK STATUS FORM

This form is provided to help determine whether an employee can return to work in a modified capacity following a **non-work-related injury or medical condition**. The City of Fort Dodge offers light-duty assignments when possible, and we are committed to supporting safe and appropriate returns to work.

EMPLOYEE INFORMATION

Employee Name: _____

Job Title: _____

Supervisor Name: _____

Date: _____

TO THE TREATING HEALTHCARE PROVIDER:

Please complete the following sections based on your professional evaluation of the employee's current medical capabilities. Be as specific as possible when identifying **functional restrictions**, such as limits on lifting, standing, walking, or the use of assistive devices. If restrictions are temporary, please include the anticipated duration or follow-up date. Your input will help us determine if a light-duty assignment is feasible and ensure that any work assigned aligns with the employee's medical needs. If you have any questions or require clarification, please do not hesitate to contact our Human Resources office at (515) 576-6869.

Section 1: Work Status

Please indicate the employee's work status (choose one):

☐ **Full Duty:** Employee may return to work **without restrictions** as of (date): _____.

☐ **Light Duty:** The Employee may return to work **with the restrictions below,** effective (date): _____, **through** (expected end date): _____.

☐ **Not Cleared:** Employee is **not able to return to work** at this time. Their **next evaluation** is scheduled on (date) _____.

Section 2: Work Capabilities & Restrictions

If Light Duty is recommended, please describe specific medical restrictions. Mark all that apply and provide specifics in the blanks:

		Restriction Details (e.g., how much, how long, how often):
☐ No ☐ Limit	Lifting	
☐ No ☐ Limit	Pushing	
☐ No ☐ Limit	Pulling	
☐ No ☐ Limit	Climbing	
☐ No ☐ Limit	Crawling	
☐ No ☐ Limit	Kneeling	
☐ No ☐ Limit	Squatting	
☐ No ☐ Limit	Walking	
☐ No ☐ Limit	Running	
☐ No ☐ Limit	Standing	
☐ No ☐ Limit	Sitting	
☐ No ☐ Limit	Grasping	
☐ No ☐ Limit	Pinching	
☐ No ☐ Limit	Repetitive bending & twisting	
☐ No ☐ Limit	Repetitive wrist motions	
☐ No ☐ Limit	Use of: ☐ Right ☐ Left ☐ Both ☐ Arm ☐ Hand	
☐ No ☐ Limit	Overhead work	
☐ No ☐ Limit	Driving	

Additional limitations & restrictions (e.g., use of assistive devices, keyboarding limitations, or other job-specific considerations):

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Duration of Restrictions: These work restrictions are expected to be **temporary**, ending on (date)

_____ unless otherwise specified by the provider.

Recommended Work Schedule:

☐ Employee can work a **full regular shift** (normal hours) **with the above restrictions.**

☐ Employee should work **modified/partial shifts:** not more than _____ hours per day and/or _____ days per week, given the above restrictions.

Follow-Up: Next medical review or follow-up appointment is on _____, or ☐ Not applicable (no further appointment scheduled).

Section 3: Healthcare Provider Information

Provider Name: _____

Medical Practice Name: _____

Address: _____

Phone Number: _____

Fax or Email (if applicable): _____

Provider's Signature: _____

Date: _____

Section 4: Employee Authorization to Release Information

I hereby authorize my healthcare provider to release the above medical information and any related work restrictions to the City of Fort Dodge for the purpose of facilitating a light duty work assignment. I understand that this information will be used only to arrange appropriate work duties and will be kept confidential. This consent is voluntary, and I understand I may revoke it in writing at any time.

Employee Signature: _____

Date: _____