



Direct Support and School Personnel – Fit for Duty

Employee Name: _____

On the basis of my findings, and to my knowledge of this staff member, I find the above-mentioned individual is physically:

Fit: _____ **Fit with**
or Restrictions:** _____ **to perform the duties of their position.**
**** (provide an explanation below if Fit with Restrictions)**

- This includes performing a physical restraint, walking and/or running for a period of time with or without reasonable accommodation.
- Must be able to lift and carry up to 25 pounds with or without reasonable accommodation.
- Must be able to be mobile in a multiple story building, with or without reasonable accommodation.

FOR OCFS PROGRAMS to include:
Residential Treatment Center (RTC), Rubin, Bessey, and SILP

This report indicates the absence of communicable disease, infection, or illness or any physical or mental condition(s) which might affect the proper care of children.

IF Fit with Restrictions answer the questions below:**

For what reason is the patient Fit with Restrictions and why?

What is the duration for the restriction? _____

Re-evaluation date, if applicable: _____

Physicians Name: _____

Physician's Address: _____

Physician's Signature: _____ Date of Physical: _____

Form may be faxed back to us to 518-283-3013. Thank you.

