Alternate Duty Medical Release

Date ____________

From: __________________________
{Name & Job Title}

To: Doctor ____________________________

1. Attached is a copy of our Alternate Duty Program.

2. Please review status of
______________________________________ and return this form to {COMPANY}. Please call if you have any questions.

❑ Patient is fit for the Alternate Duty Program

❑ Patient is not fit for the Alternate Duty Program (State Reasons)

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❑ Patient is fit for light / limited duty

3. Limited/Light Duty Limitations Associated Limitations

❑ No prolonged standing

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❑ No prolonged walking

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- ❑ No prolonged sitting

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- ❑ No knee bending, squatting, kneeling

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- ❑ Limited or no use of _________

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- ❑ Weight lifting restrictions

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- ❑ Keep affected area elevated

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- ❑ Keep dressing dry and clean

____

- ❑ Use crutches/sling/splint

____

- ❑ Other ___________________

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