Date of Appointment _____

Employer _____

Provider Clearance To Perform Job Functions

**** It is the PATIENT's responsibility to obtain needed medical information from treating provider for clearance ****

I, _____, am currently treating, _____(_____),
Treating Provider/Specialist *Patient Name (please print clearly)* *Date of Birth*

for _____. This condition is well controlled, and in my opinion patient
Condition/Diagnosis

is physically/mentally able to safely work as a _____, with:
Job Description

☐ **No Restrictions**

☐ **The following restrictions (be specific) :** _____

and is not currently taking any medication(s) that would impair his/her ability to safely perform job duties.

Bus drivers/attendants must be physically capable of:

- **Dragging 125 pounds for thirty feet.**
- **Making three trips up and down the stairs.**
- **Self-evacuation out of the back emergency door.**
- **Foot/hand controls in set times.**
- **Removing passengers if put in such an emergency situation.**

<u>STAMP</u> REQUIRED FROM TREATING PROVIDER

Name Of Facility _____
Address _____
Phone Number_____fax#:_____
Provider's Printed Name And Title _____

_____
Signature Of Treating Provider/Specialist ***Date***

RETURN (mail or fax) TO:

Occupational Safety On Site, Inc.
1600 Lyell Ave., Suite C
Rochester, NY 14606
PH: (585) 723-3891
FAX: (585) 225-0172