Virginia Appalachian Tricollge Nursing Program

Fitness for Duty- Return to Classroom and Clinical Courses

Form B

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<tr>
<th>Student Name:</th>
<th>EMPL ID:</th>
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This form is required for all students who have experienced an illness, injury, pregnancy, hospitalization or other circumstance which resulted in either a physical or psychological limitation(s) or an absence from the program.

Please use the following information to determine if this student can return to the classroom and clinical setting.

- Each clinical day is 8-12 hours in length
- Students are expected to complete nursing care activities comparable to that of a staff nurse with the supervision of their clinical instructor
- Physical demands in the nursing program include duties that frequently require squatting, bending, kneeling, reaching, and stair climbing, lifting and carrying up to 50 pounds; frequent pushing and pulling up to 200 pounds with assistance; occasional lifting up to 200 pounds with assistance and occasional carrying up to 51-74 pounds. Duties also require constant use of sense of sight, hearing, touch, and speech. Environmental conditions include procedures that involve handling blood and body fluids using standard (universal) precautions.

Please indicate your recommendation regarding this student’s ability to return to the classroom/clinical setting. The student must be free of any restrictions or limitations which may endanger the student’s health or a client’s safety in the clinical setting.

- I find the above named student fit for duty with NO restrictions or limitations in the classroom or clinical setting
- I find the above named student fit for duty WITH the following restrictions or limitations: _______________________________________________________________
  _______________________________________________________________
  _______________________________________________________________
  _______________________________________________________________
- I find the above named student NOT fit for duty; may reconsider after __________(date)

Healthcare Provider Signature/Title: ____________________________ Date: ____________