



Division of Human Resources

EMPLOYEE FITNESS FOR DUTY

DATE: _____

TO: Health Care Provider

As a condition of return to work, the employee who is on leave due to a serious health condition must have a medical examination. This form must be completed by you, as his/her health care provider, before the employee is allowed to resume his/her job duties.

Employee Name: _____

Employee's Job Title: _____

1. Date of Medical Examination: _____
2. Please indicate with a check mark the status of the employee's release for duty.
 _____ The employee is able to return to work as of _____ (date) without restrictions.
 _____ The employee can return to work as of _____ (date) with the following restrictions which are expected to last through _____ (date). **(complete restrictions chart below.)**
3. Estimated date that employee will be able to return to full, unrestricted duty _____
4. Date of your next medical evaluation of the employee: _____

Complete this section if the employee is being released to work with restrictions.

PHYSICAL/OTHER EXAMINATIONS	FULL RESTRICTIONS	PARTIAL RESTRICTIONS	NO RESTRICTIONS
Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (how many hrs)			
Standing (how many hrs)			
Sitting (how many hrs)			
Stooping (how many hrs)			
Kneeling (how many hrs)			
Repeated Bending (how many hrs)			
Climbing (how many hrs)			
Operating a motor vehicle, etc.			
Other: maintain emotional control under stress			
Exposure Limitation (cold/heat):			

EMPLOYEE NAME: _____

5. Based on my review of the employee's job description, the employee also has the following restrictions or required accommodations:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

6. I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury at _____, this _____ day of _____, _____.
- (List City and State) (month) (year)

Signature of Health Care Provider

Date

Print Name of Health Care Provider

Phone Number

Type of Practice

License No.

Address

City State Zip