FITNESS FOR DUTY FORM

Return completed form to employer prior to returning to work.

EMPLOYEE INFORMATION AND INFORMED CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION
Name
Address
Telephone Number

STATEMENT OF PHYSICAN OR PRACTITIONER
Medical Facts Regarding Patient's Condition:
Date Condition Commenced: Probable Duration of Condition:
Has patient reached the end of his/her healing period? Yes ☐ No ☐ Is patient able to perform all of the functions of his/her regular job?
If essential functions were provided, please indicate any that are of concern in light of employee's current condition.
Is patient able to work his/her normal work schedule? Yes ☐ No ☐ (If not, please identify the number of hours per day and the number of hours per week that the patient can work, and the expected duration of the period of the reduced schedule.)
Is patient able to return to work without posting a significant risk or substantial hard to him/herself or others?
When can patient return to work? Restrictions? Yes ☐ No ☐ If yes, describe what restrictions apply in comments Comments:
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requirement genetic information of employees or their family member. In order 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 family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.
Physician Signature Date

PHYSICIAN OR PRACTITIONER INFORMATION		
Physician Name		
Address		
City	State	Zip Code
Telephone	Field of Specialty	License No.

MAINTAIN THIS FORM IN A FMLA CONFIDENTIAL FILE