Fitness for Duty Form

Employee Name: _____ Phone: _____

Physical Address: _____

Dear Healthcare Provider:

The above-named employee has disclosed a condition that could interfere with their ability to perform the essential functions of their position. They have indicated that you are currently providing treatment for this condition. We ask that you review the employee's job description that accompanies this document and respond fully to our inquiries below. We ask that you be as specific as possible, defining subjective terms such as "excessive" and "limited." You may include additional comments, as needed, related to the condition and its impact on the employee's ability to perform the essential functions of their position. When complete, you may email this document to **HRLeaveMgmt@imacorp.com.**

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 a 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 members' 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. We appreciate your cooperation in assisting us to avoid any unnecessary and inadvertent disclosure of genetic information to our company.

REQUEST FOR INFORMATION AND RETURN TO WORK STATUS:

1. Approximate date the patient's condition commenced: _____

2. Probable duration of the condition 3. Date(s) you have treated the patient: _____

4. Is the employee currently prescribed medication for this condition? YES _____NO_____

5. If yes, can the medication interfere with the patient's ability to complete one or more of the essential functions of their position, as described in the job description? YES _____NO_____

6. If yes, how? Which job functions? (Please be specific): _____

7. Does the employee's condition prevent them from performing one or more of the essential functions of their job?

_____

_____

8. Does the condition pose a significant risk of harm to others?

_____

9. Please check the appropriate box below and provide additional details as requested regarding the employee's current ability to return to work:

☐ Employee may return to work with **no** restrictions as of: _____ (mm/dd/yyyy)

☐ The employee may return to work on _____(mm/dd/yyyy) with the following restrictions:

Lifting: _____

Pushing/ Pulling: _____

Carrying: _____

Bending: _____

Stooping: _____

Squatting: _____

Kneeling: _____

Climbing: _____

Other: _____

☐ The employee is not released to return to work at this time. Their progress will be reassessed during the next scheduled follow up appointment on: _____ (mm/dd/yyyy) at _____am/ pm.

I estimate that the employee will be able to return to work on or around _____.

HEALTHCARE PROVIDER INFORMATION (Please print clearly):

Signature: _____ Date: _____

Printed Name: _____Title: _____

Address: _____

Phone Number: _____Fax Number: _____