**Fitness For Duty/Return to Work Medical Evaluation**

(Job Description Attached)

Provide completed form to employee or mail to: **Tim Marker**, Human Resources, Wenatchee Valley College, 1300 Fifth Street, Wenatchee WA 98801

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| **Employee Information and Informed Consent for Disclosure of Health Care Information** | | |
| Employee Name (please print): | | Date of Birth: |
| Address: | | |
| Telephone Number: | | |
| **AUTHORIZATION TO RELEASE INFORMATION:**  I hereby authorize my health care provider to release and disclose to **myself and/or the person named above,** such health care records and information concerning my current medical condition as is necessary to determine my fitness for employment and/or return to work.  Employee Signature: Date: | | |
| **Statement of Health Care Provider\*** | | |
| Date patient was last examined: | | |
| After reviewing the patient’s job description, would you place any restrictions on the patient’s performance of any job functions? **❑** Yes **❑** No | | |
| If the patient is able to return to work with restrictions, please list what the restrictions are: | | |
| Is patient able to work his/her normal work schedule of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_? ❑ 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 for the reduced schedule: | | |
| This patient can return to work **with** restrictions on (date): | | |
| This patient can return to work **without** restriction on (date): | | |
| Additional comments: | | |
| I certify that the above representations accurately reflect my informed medical opinion with regard to this patient and the patient’s fitness for duty and ability to return to work at this time.  Health Care Provider Signature\*: Date: | | |
| **Health Care Provider Information** | | |
| Health Care Provider Name (please print): | | |
| Address: | | |
| City, State, Zip: | | |
| Telephone: | Field of Specialty: | |

\*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. 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.

Fitness for Duty/Return to Work Form 4/11 tm