

# Pima County FMLA Fitness For Duty Report



01/2011



Pima County HR-FMLA will require this form in order for you to return to your regular position after continuous FMLA leave or to remove existing work restrictions. Please contact HR-FMLA at 520-740-8076 with any questions.

EMPLOYEE INFORMATION		
Name:		Dept:
Home phone:	Cell phone:	Work phone:
Supervisor Name:		Supervisor phone:

INSTRUCTIONS TO HEALTH CARE PROVIDER
<p>This form is to be completed by the health care provider when the employee has been released to work. It should address the ability of the employee to perform the essential functions of the job. Please also read the statement below. <b>Completed form may be faxed to 520-791-6514.</b> Please contact HR-FMLA at 520-740-8076 with any questions.</p> <p>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. <b>To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information.</b> '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.</p> <p><input type="checkbox"/> If checked, Essential Job Function Analysis form (Form EFA) is attached for reference.</p>

STATEMENT OF HEALTH CARE PROVIDER
<p>Patient is able to return to work on date (mo/day/year) : _____ with the following restrictions:</p> <p><input type="checkbox"/> None. Employee is able to perform <u>all</u> the essential functions of the job.</p> <p><input type="checkbox"/> Reduced work schedule. Employee is able to work only # _____ hours per day, # _____ days per week Until date (mo/day/year) : _____</p> <p><input type="checkbox"/> Other restrictions. Please list the essential functions the employee is unable to perform.</p> <p>Restrictions are in place until date (mo/day/year) : _____</p>

Comments:		
<b>Please note: Incomplete or unsigned forms will be returned to the health care provider for completion and/or clarification.</b>		
Provider Signature:		Date (mo/day/year) :
Provider Name (please print clearly):		
Phone:	Fax:	Field of Specialty: