

# Pima County FMLA Fitness For Duty Report



Have this form completed by your health care provider and fax to HR-FMLA (secure fax # 520-791-6514) prior to or upon your return to work. Pima County HR-FMLA will require this form in order for you to return to your regular position after continuous FMLA leave. Please contact HR-FMLA at 520-740-8076 with any questions.

<b>EMPLOYEE INFORMATION AND INFORMED CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION</b>		
Employee's Name:		Phone:
Address, City, State, Zip:		
<b>AUTHORIZATION TO RELEASE INFORMATION:</b>		
<p>I hereby authorize the health care provider identified below to release and disclose to <b>Pima County</b> such health care records and information concerning my current medical condition as is necessary to determine my fitness for employment and/or eligibility for any employer-provided benefit. This authorization shall be valid for two (2) years from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation will not apply to any information that has already been released in reliance on this authorization, and that any revocation may have an adverse effect on the receipt of employer-provided benefits.</p>		
Employee Signature:		Date:
<b>STATEMENT OF HEALTH CARE PROVIDER</b>		
Has patient reached the end of his or her healing period?    Yes    No		
Is patient able to perform all essential functions of his/her regular job?    Yes    No		
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 for the reduced schedule:		
Is patient able to return to work without endangering him/herself or others?    Yes    No		
Date patient can return to work without restrictions? _____ (Date)      With restrictions? _____ (Date)		
Comments:		
Provider Signature:		Date:
<b>HEALTH CARE PROVIDER INFORMATION</b>		
Provider Name:		
Address:		
City, State, Zip:		
Telephone:	Field of Specialty:	License No.: