Fitness For Duty/Return to Work Medical Evaluation

Provide completed form to employee or mail to: **Jessica Miller**, Benefits Manager, Columbia Basin College, 2600 N. 20th Ave, Pasco, WA 99301

Employee Information and Informed Consent for Disclosure of Health Care Information	
Employee's Name (please print):	Department:
Employee's Position:	
Date Leave Commenced:	
Date Planned to Return to Work:	

Statement of Health Care Provider

Date patient was last examined:

I certify that on _____, _____is able to resume performing
(Date) (Name of Patient/Employee)
the functions of his/her position, with or without the following work restrictions:

Additional comments:

I certify that the above representations accurately reflect my 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: