FITNESS FOR DUTY/RETURN TO WORK MEDICAL EVALUATION

EMPLOYEE INFORMATION (To be completed by Employee)		
Name (Last, First, MI)	**Job Title/Department**	**Employee ID #**
Home Mailing Address (Street/PO Box, City, State, Zip Code)		**Personal Phone**
Date Leave Commenced	**Date Planned to Return to Work**	

INFORMED CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

I authorize the health care provider identified below to provide the information requested on this form for the purpose of determining my fitness for duty and for designated CBC Human Resources personnel to contact the health care provider to authenticate and/or clarify the information provided, if necessary. I understand that if I do not agree to this authorization, my return to work may be delayed or denied.

Employee Signature	**Date**

STATEMENT OF HEALTH CARE PROVIDER (To be completed by Health Care Provider)

GINA Notification to Health Care Providers: 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. 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.

Name of Patient/Employee	**Date Patient was Last Examined**

Is the employee able to perform the essential functions of his/her position without restrictions? ☐ **YES** ☐ **NO**

- If **YES**, the employee is fully released to return to work on ____/____/____.
- If **NO**, the employee is released to return to work on ____/____/____ according to the restrictions outlined below. Work restrictions are in place until ____/____/____ after which point employee will be fully released without restrictions on ____/____/____.

Please list the essential functions the employee is unable to perform and/or provide details regarding reduced work schedule (if applicable): _____

_____

_____

_____

_____

HEALTH CARE PROVIDER INFORMATION	
Name of Health Care Provider (Please Print)	**Type of Practice/Specialty**
Address (Street/PO Box, City, State, Zip Code)	**Phone**
Health Care Provider Signature	**Date**

RETURN COMPLETED FORM TO CBC HUMAN RESOURCES OFFICE
2600 N. 20TH AVE. (MS-A2), PASCO, WA 99301 | FAX: (509) 544-2029 | PHONE: (509) 544-4927