



FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION

TO: Team Member

Team Members will need to provide this completed and signed Fitness for Duty Form from their treating physician, approving a return to work and specifying any physical restrictions or limitations. At the end of your leave, it is also your responsibility to let your Team Leader and HR Business Partner, know of your exact return to work date.

The Fitness for Duty Form must be emailed to your HR Business Partner and eServices@inova.org (or faxed to eServices at 703-205-2144) no later than 2 days prior to the actual date you will return to work. Also, if you have restrictions or limitations for your return to work, this form must be provided to The Hartford by email: GBClaims@thehartford.com or uploaded to The Hartford portal at https://thehartford.com/mybenefits It is the Team Member's responsibility to follow up with their treating physician to get this form completed.

Please note, all changes should be made in Oracle by your Team Leader and cannot be predated. Any changes take 24 hours to be reflected in Oracle. Failure to provide this completed Fitness for Duty in a timely manner will delay your return to work as well as updates to your employment status and pay and will disrupt reinstatement of your Inova email and access to internal systems.

TO: Health Care Provider

This form must be completed by you, as the employee's health care provider, before the employee can resume his/her job duties. Please use the following guidelines in completing this form:

- Full, unrestricted duty – the patient has no work restrictions and can return to his or her prior position.
- Modified duty – the patient has some work restrictions. Work restrictions must be specifically notated on pages two - four of this form.
- Not released – the patient is not released to return to work in any capacity.

GINA PROVISION. 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.

1. Employee Name: _____

2. Employee's Job Title: _____

3. Date of Examination: _____

4. Please indicate with a check mark the status of the employee's release for duty.

[] Full, unrestricted duty effective _____.

[] Modified duty effective _____. (Please complete question 5.)

[] Not released for any type of duty.

5. If you are releasing the employee to modified duty, please complete the following:

a. Estimated date the employee will be able to return to full, unrestricted duty: _____.

b. Date of employee's next medical evaluation: _____.

- c. Indicate the exact work restrictions which apply to the employee **at this time** on the chart below. Please use additional sheets of paper if needed.

Complete this section if the employee is being released to modified duty.

PHYSICAL EXAMINATIONS	FULL UNRESTRICTED DUTY	MODIFIED DUTY (please specify)	NOT RELEASED
Sedentary Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs)			
Standing (hrs)			
Sitting (hrs)			
Stooping (hrs)			
Kneeling (hrs)			
Repeated Bending (hrs)			
Climbing (hrs)			
Operating a motor vehicle, powered industrial truck, forklift, etc.			
Number of hours worked (per day or week)			
Finger Manipulation (typing)			
Pain (frequency, degree, signs)			
Other:			
Behavioral Evaluation	FULL UNRESTRICTED DUTY	MODIFIED DUTY (please specify)	NOT RELEASED
Understanding			
Remembering			
Sustained concentration			
Follow-through on instructions			
Decision making			
Receiving supervision			
Relating to co-workers			

6. Other restrictions, considerations, or notes: _____

I certify that the above information is true and correct to the best of my knowledge.

Signature of Health Care Provider

Date

Print Name of Health Care Provider

Phone Number

Address City State Zip

Type of Practice

License No.