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. It is the Team Member's responsibility to follow up with their treating physician to get this form completed.

The Fitness for Duty Form must be submitted to eServices@inova.org or faxed to 703-205-2144 no later than 2 days prior to the actual date you will return to work. 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 will disrupt reinstatement of your Inova email and access to internal systems.

At the end of your leave, it is also your responsibility to let your Team Leader, as well as your HR Business Partner, know of your exact return to work date. 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.

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 that employee will be able to return to full, unrestricted duty: _____.

   b. Date of your next medical evaluation of the employee: _____.

   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. _____