

Form E

FITNESS FOR DUTY FORM

EMPLOYEE:

Return completed form to employer prior to returning to work

Employee Information and Informed Consent for Disclosure of Health Care Information

Name: _____

Address: _____

Telephone Number: _____

Authorization to Release Information:

I hereby authorize the physical or practitioner identified below to release and disclose to _____ or its employees or representatives of such healthcare 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.

Employee Signature: _____

Date: _____

STATEMENT OF PHYSICIAN OR PRACTITIONER

Medical Facts Regarding Patient's Condition:

Date Condition commenced: _____ Probably Duration of Condition: _____

Has patient reached the end of his/her healing period? Yes No

Is patient able to perform all of the 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 the patient able to return to work without posing a significant risk or substantial harm to him/herself or others?

Yes No

When can patient return to work? _____ Restrictions? Yes No

If restrictions apply, describe:

PHYSICAL OR PRACTITIONER INFORMATION

Physician Name: _____

Address: _____

Telephone: _____ Field of Specialty: _____ License #: _____