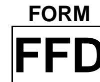
Pima County Family and Medical Leave (FML) Fitness For Duty Report



Pima County HR-FMLA requires this completed form in order for the employee to return to his/her regular position after continuous FML or to remove existing work restrictions. Please contact HR-FMLA at 520-724-8076 with any questions.

EMPLOYEE INFORMATION

Name :		EIN:	Dept:
Work phone:	Home phone:		Cell phone:
Supervisor Name:			Supervisor phone:

INSTRUCTIONS TO HEALTH CARE PROVIDER

This form is to be completed by the health care provider when the employee has been released to work. It must address the ability of the employee to perform the essential functions of the job. Please also read the statement below.

☐ If checked, Essential Job Function Analysis (Form EFA) is attached for reference.

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. '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. **To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information.**

Completed form may be faxed to HR-FMLA at 520-791-6514. Please do not send medical information by email.

STATEMENT OF HEALTH CARE PROVIDER

Employee is able to return to work on date (mo/day/year) ____________________ **with the following restrictions:**

☐ **None**. Employee is able to perform ALL the essential functions of the job.

☐ **Reduced work hours**. Employee is able to work **only** #________ hours per day, #________ days per week until date (mo/day/year) : ______________________________

☐ **Other restrictions.** List essential functions employee is unable to perform. For FMLA purposes, "light duty" does not provide adequate information.

These restrictions are in place until date (mo/day/year) : ______________________________

Comments: (e.g. follow-up appointments, flare-ups)

Please note: Incomplete or unsigned forms will be returned to the health care provider for completion and/or clarification.

Provider Signature:		Date (mo/day/year) :
Provider Name (please print clearly):		
Phone:	Fax:	Field of Specialty: