Gadsden City Schools

FITNESS FOR DUTY FORM

1. Employee: Have your **treating physician** review your **attached job description** and ask him/her to complete this form. You must return the completed form to your immediate supervisor before you can be eligible to return to work.

Employee name:_____

Employee Address:_____

Employee Phone Number:_____

I, the undersigned Employee, hereby authorize the physician or practitioner identified below to release and disclose to Gadsden City Board of Education or its employees or representatives, 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:_____

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2. Treating Physician: The Employee is employed as a _____with employer.

Please review the **attached job description** for this employee, complete this form, and return it to the patient.

Diagnosis/Medical Facts/Type of condition:_____

_____

_____

Date the condition began: _____Probable duration of condition:_____

Is employee able to perform the essential functions of the job as set forth on the attached job description? YES_____ NO_____

If not, which functions are of concern?_____

_____

Is employee able to return to work without posing a significant risk or substantial harm to him/herself, patients, employees or others?

YES___ NO____ Explanation (if any)_____

Is the employee able to return to work without restrictions? YES_____ NO_____

Please indicate any restrictions or comments (if any)_____

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3. Signature:

Signature of Health Care Provider: _____Date:_____

Printed Name of Health Care Provider: _____

Address of Health Care Provider:_____

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 DISCLOSURE 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 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.