This form is to be completed by the employee's current treating health care provider.

Fitness for Duty / Return to Work Certification

*An employee coming off of leave for surgery, extended illness, injury or other medical reason must present this Fitness for Duty Certification to Human Resources **prior** to returning to work.*

Health Care Professionals: Your patient has three return to work options. Review the essential duties and physical requirement of the attached job description prior to completing this form. If the job description is **not** attached, DO NOT complete.

- **Full Release.** The patient has no work restrictions. They can return to his or her prior position because you, the health care provider certify, that he or she can perform ALL the essential functions and meet the physical requirements of their job without any restrictions or accommodations.

- **Modified Duty.** The patient has some work restrictions. Work restrictions must be specifically notated on page two of this form. Each modified duty work restriction request will be reviewed carefully to determine if the employee can perform the essential functions of the job and return to work.

    - If the modified duty is temporary, list when the modified duty should end.

- **Not Released.** The patient is not released to work in any capacity due to physical or behavioral limitations.

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.

Submission:

The Fitness for Duty / Return to Work Certification need to be submitted to the fax or email below:

To: OKCPS Human Resources
Fax: 405-587-0829
Email - leave@okcps.org

For question, contact

Mechele Berry	ph 405-587-0827	For Central Office or school site employees
Jane Pierce	ph 405-5870-814	For Central Office or school site employees
Shayna Rivera	ph 405-587-0813	For Central Office or school site employees
Anne Swan	ph 405-587-0194	For Operations based employees

Oklahoma City Public Schools Human Resources

Fitness for Duty / Return to Work Certification

Employee / Patient _____ **Date of Medical Examination** _____

Employee Supervisor_____ **Site/Department**_____

Please check the status of the employee's release for duty

☐Full, unrestricted duty effective _____
☐Modified duty* effective _____ ☐ Permanent Restriction ☐ Temporary Restriction
*complete sections 4, 5 and 6
If Temporary restriction is listed, when is the end date of the restriction _____
☐Not released for any type of duty. Next evaluation date will be _____

4. Physical Evaluation

	Full Restrictions	Partial Restrictions (please specify)	No Restrictions
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 / Standing			
Stooping/Bending			
Kneeling			
Climbing			
Operating a motor vehicle			
Finger Manipulation (typing)			
Pain (frequency, degree, signs)			

5. Behavioral Evaluation

	Able to perform	Other Considerations (please specify)	Not Able to perform
Understanding			
Remembering			
Sustained concentration			
Follow-through on instructions			
Decision making			
Relating to co-workers and students			

6. List any restrictions, considerations or notes to help us accommodate the employees. Also, list any medication the employee is on that may hamper the employees ability perform the essential duties of their job.

_____

_____

_____ _____ _____

Printed Name Treating Health Care Provider Date Phone Number

I hereby certify that I am the employee's current treating health care provider and that the facts in this document are true and correct.