DELAWARE HEALTH AND SOCIAL SERVICES
FITNESS FOR DUTY CERTIFICATION

This form must be completed and returned to your immediate supervisor/manager prior to your return date. Failure to do so may delay your return to work. Additional questions may be asked of your treating physician in order to better evaluate your return to work.

PART 1. TO BE COMPLETED BY EMPLOYEE

{Current job description must be included with this document and presented to physician}

Employee Name _____ Date of Illness/Injury _____
Job Title _____ Division/Department _____
Supervisor's Name _____
Job Status

☐ Full-time Work Week _____
☐ Part-time Work Hours _____

PART 2. TO BE COMPLETED BY TREATING PHYSICIAN

Notification To Healthcare Provider

Title II of the Genetic Information Nondiscrimination Act (GINA) "prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees of their family members. In order 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 test, 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."

Please select one of the following

☐ Employee is **UNABLE** to return to work at this time.
Effective Date _____

☐ Employee is **ABLE** to return to work with restrictions**
Effective Date _____

** REQUIRES TREATING PHYSICIAN TO COMPLETE FUNCTIONAL ABILITIES FORM

☐ Employee is **ABLE** to return to work **WITHOUT** restrictions
Effective Date _____

Please describe medical facts that support employee's work restrictions or employee's inability to return to work.

_____
_____
_____
_____
_____

PART 2. TO BE COMPLETED BY TREATING PHYSICIAN

Employee may perform transitional work from _____ [Beginning Date] until _____ [Ending Date]

Are modified work hours required?

☐ Yes
☐ No

If yes, modified hours _____ [Beginning Date] modified hours _____ [Ending Date]

Employee can work _____ hours/day and/or _____ hours/week.

Employee can resume regular work schedule effective _____

Employee's next examination/treatment date _____

_____ **[Treating Physician's Signature]** _____ **[Date]**

_____ **[Print Treating Physician's Name]** _____ **[Type of Practice]**

_____ **[Address]**

_____ **[Telephone Number]** _____ **[Fax Number]**

_____ **[E-Mail Address]**

Thank you for completing these documents.

Please return to the attention of _____

Department _____

Fax Number _____

Contact Number _____

ORIGINAL FORMS MUST BE PRESENTED TO YOUR IMMEDIATE SUPERVISOR/MANAGER AND/OR ACT CASE MANAGER

These forms do not substitute for information required by other healthcare providers, workers' compensation insurers, private insurers, or FMLA covered events.

DHSS FUNCTIONAL ABILITIES FORM

The purpose of this form is to identify your patient's overall functional abilities and work restrictions that will assist their return to suitable work.

Please check the appropriate boxes.

*No Restrictions

GENERAL PHYSICAL ACTIVITIES

Activity	Total Consecutive Hours Employee Can Perform Specified Activity									
	0	1	2	3	4	5	6	7	8	*N R
Sit										
Stand										
Walk										
Bend										
Kneel										
Squat										
Climb										

Employee can alternate with sitting/standing every _____ hour(s).

HAND/WRIST ACTIVITIES

Activity	Total Consecutive Hours Employee Can Perform Specified Activity									
	0	1	2	3	4	5	6	7	8	*N R
Grasp										
Right Hand										
Left Hand										
Reach										
Right Hand										
Left Hand										
Push/Pull										
Right Hand										
Left Hand										
Fine Manipulation										
Right Hand										
Left Hand										
Use Keyboard										

WEIGHT HANDLING ACTIVITIES

Activity	Number Of Times Per Hour					
	0	1 to 10	10 to 15	15 to 20	20/more	*N R
Lift						
< 10 lbs.						
10-20 lbs.						
20-50 llbs.						
50-100lbs.						
Carry						
< 10 lbs.						
10-20 lbs.						
20-50 llbs.						
50-100lbs.						
Push						
< 10 lbs.						
10-20 lbs.						
20-50 llbs.						
50-100lbs.						
Pull						
< 10 lbs.						
10-20 lbs.						
20-50 llbs.						
50-100lbs.						

Is employee restricted by environmental factors; such as heat/cold, dust, dampness, heights, chemicals, fumes, gases, odors, notice, vibration, etc.?

☐ No
☐ Yes

If yes, please explain _____

_____

COGNITIVE LIMITATIONS

Please check appropriate boxes and provide comments.

☐ Memory
☐ Concentration
☐ Fatigue
☐ Interaction With Others
☐ Emotional Stability
☐ **No** Cognitive Limitations Are Evident

Additional Comments _____

_____

Please provide any additional information as it relates to the employee's current functional abilities.

_____

_____

_____

_____