



## State of Colorado Fitness-To-Return Certification

**Instructions to Employee:** Return this form to your department/institution before or on the day you return to work.

Employee's Name	Employee ID #:
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**Instructions to Department/Institution:** Attach the job duty statements from the official Position Description Questionnaire (PDQ). This completed form is to be placed in a separate, confidential medical file with limited access.

Pursuant to the Genetic Information Nondiscrimination Act (GINA)'s "safe harbor" provision in 29 CFR § 1635.8(b)(1)(i), the GINA disclosure language must be included with any request for employment-related medical information or examinations (e.g., FMLA for employee, ADA, Fitness-for-Duty exams, Workers' Compensation exams, post-offer/pre-employment exam, etc.) for the individual's own condition.

**Instructions to Health Care Provider:** Please complete this form when the employee is seeking your release to return to work.

**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.**

1.	Date the condition began.
2(a)	Check one of the following. <input type="checkbox"/> The employee is able to work a full, regularly scheduled day with no restrictions beginning (date). <input type="checkbox"/> The employee is unable to return for any work until _____ (date). <input type="checkbox"/> The employee is able to return to work on a reduced schedule for _____ hours per day from _____ (date) through _____ (date). <input type="checkbox"/> The employee is able to return to work with restrictions from _____ (date) through _____ (date). Please complete next section (b).
(b)	Please indicate restrictions. <input type="checkbox"/> no lifting or carrying objects: _____ max. lbs. Repetitions <input type="checkbox"/> no pushing/pulling objects: _____ max. lbs. Repetitions <input type="checkbox"/> no bending/stooping/squatting/twisting: Repetitions <input type="checkbox"/> no kneeling for more than _____ hours each day <input type="checkbox"/> no crawling for more than _____ hours each day <input type="checkbox"/> no sitting for more than _____ hours each day <input type="checkbox"/> no standing for more than _____ hours each day <input type="checkbox"/> no walking for more than _____ hours each day <input type="checkbox"/> no climbing stairs <input type="checkbox"/> no working/climbing on elevated equipment (ladders, stools, roofs, poles, etc.) for more than _____ hours each day <input type="checkbox"/> no reaching above the head or shoulders <input type="checkbox"/> no reaching away from the body greater than _____ with <input type="checkbox"/> right <input type="checkbox"/> left arm <input type="checkbox"/> no grasping objects with <input type="checkbox"/> right <input type="checkbox"/> left hand

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- ☐ no fine manipulation with ☐ right ☐ left hand
  - ☐ no assaultive, physical control, and/or arrest situations
  - ☐ no driving a vehicle
  - ☐ no operating machinery or equipment
  - ☐ no working alone
  - ☐ no use of firearms
  - ☐ no typing, keyboarding, or entering data for more than \_\_\_\_\_ hours each day
  - ☐ no use of a CRT or computer monitor for more than \_\_\_\_\_ hours each day
  - ☐ no use, including repetitive, of \_\_\_\_\_ (extremity/joint)
  - ☐ no weight bearing on \_\_\_\_\_ (extremity)
  - ☐ Other restrictions (specify): \_\_\_\_\_
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3. Other instructions: \_\_\_\_\_

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Based on my personal evaluation of the patient's condition, the above information is accurate and complete.

**Signature of Health Care Provider** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Type of Practice** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_

**Email:** \_\_\_\_\_