convergint

FAMILY & MEDICAL LEAVE ACT (FMLA) FIT FOR DUTY CERTIFICATION

DO NOT PROVIDE MEDICAL DOCUMENTATION TO YOUR SUPERVISOR – SUBMIT DIRECTLY TO HR BUSINESS PARTNER

Prior to returning to work, you must provide a Fit for Duty Certification verifying whether you are able to return to work, if you have any job-related restrictions, and the duration of any restrictions. You must return this completed Fit for Duty Certification form to Human Resources as requested, or your return to work may be delayed or denied under the FMLA.

Please have your health care provider complete this form and return it to your HR Business Partner by: _____

SECTION A: TO BE COMPLETED BY COLLEAGUE

I authorize my health care provider to supply Human Resources with the requested data for the purpose of determining whether I am fit to return to work after my FMLA leave. In addition, I authorize my health care provider to provide to Human Resources information regarding my fitness to return to work for the purposes of clarifying or authenticating information previously provided, or to provide missing information. I understand that the information I provide will be accessed by authorized personnel whose jobs reasonably require access.

Colleague Name:_____

Colleague Signature:_____ Date:_____

SECTION B: TO BE COMPLETED BY HEALTH CARE PROVIDER

The above colleague is required to provide a complete and sufficient Fit for Duty Certification, completed by his or her health care provider, prior to returning to work from FMLA leave.

This certification is being sought only with regard to the particular medical condition that caused the colleague's need for FMLA leave.

☐ I certify that, with regard to the particular medical condition that caused the colleague's need for FMLA leave, the colleague is fit for duty and able to resume work as further noted below:

☐ Full/unrestricted duty, effective:_____ ☐ Modified duty, effective:_____

If modified duty, please describe restrictions, as well as duration of restrictions:

_____

_____

☐ I certify that, with regard to the particular medical condition that caused the colleague's need for FMLA leave, the colleague is not released to return to work.

I hereby certify that the above colleague is currently my patient and declare that the statements made in this Fit for Duty Certification are true and correct.

Provider name:_____ Phone number: _____

Provider signature:_____ Date:_____

Address: _____

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.