TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO

Return to Work/Fitness for Duty

Please return this completed and signed form to Leave Administration: ELPHRleaveadmin@ttuhsc.edu or Fax 915-783-5157

To be completed by employee	
Employee Name	R#
Department	Supervisor Name

I understand that if my release includes workplace restrictions related to my medical condition, this form must be returned to Human Resources two days prior to my return to work date. I understand that my return to work date may be delayed so that Human Resources can initiate administrative review of my return to work/duty. If restrictions are substantially limiting, are expected to continue longer than 3 months, or are considered permanent, your return release will be referred to the ADA coordinator for review under the ADA law.

Employee Signature	Date

To be completed by Treating Healthcare Provider

A. The employee is able to work a full, regular schedule with no restrictions, beginning (date)_____

B. The employee is able to return to work on a reduced schedule required by this condition beginning (date)_____through (date) _____

- Reduced schedule maximum **weekly** work hours _____
- Reduced schedule maximum **daily** work hours _____
- Follow up appointment _____

C. The employee is able to return to work with restrictions required by this condition beginning(date)_____through(date)_____

Limitation in the number of hours worked: Work no more than _____ hours/**day** Work no more than _____ hours/**week**

Frequently = 34%-66% of the time - Occasionally = 1%-33% of the time

- Lift up to _____pounds ☐ Frequently or ☐ Occasionally
- Push/pull/force up to _____ pounds ☐ Frequently or ☐ Occasionally
- Bend, twist, stoop ☐ Frequently or ☐ Occasionally
- Reaching ☐ Frequently or ☐ Occasionally

During Work Hours: Stand no more than____hours Walk no more than____hours Sit no more than____ hours

Additional Major Life Activities:

☐ Concentration ☐ Think ☐ Hear ☐ Learn ☐ Performing Manual Task ☐ Caring for Oneself

☐ Interact with others ☐ Sleep ☐ Eat ☐ Read ☐ Communication ☐ Other _____

☐ Work ☐ Sight ☐ Breathe ☐ Speak ☐ Major Bodily Functions (Please List) _____

Other restrictions related to the employee's ability to perform essential functions (please explain):

Type of Practice/Specialty	Treating Healthcare Provider Print Name	Provider Signature and Date

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 do 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 reproduction services.