Fitness For Duty/Return to Work Medical Evaluation
(Job Description Attached)

Provide completed form to employee or mail to: Vice President of Human Resources, Walla Walla Community College, 500 Tausick Way, Walla Walla, WA 99362

Employee Information and Informed Consent for Disclosure of Health Care Information

Employee Name (please print):	Date of Birth:
Address:	
Telephone Number:	

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize my health care provider to release and disclose to **myself and/or the person named above,** such health care records and information concerning my current medical condition as is necessary to determine my fitness for employment and/or return to work.

Employee Signature: Date:

Statement of Health Care Provider

Date patient was last examined:

After reviewing the patient's job description, would you place any restrictions on the patient's performance of any job functions?

❑ Yes ❑ No

If the patient is able to return to work with restrictions, please list what the restrictions are:

Is patient able to work his/her normal work schedule of _____? ❑ Yes ❑ No
If not, please identify the number of hours per day and the number of hours per week that the patient can work, and the expected duration of the period for the reduced schedule:

This patient can return to work **with** restrictions on (date):

This patient can return to work **without** restriction on (date):

Additional comments:

I certify that the above representations accurately reflect my informed medical opinion with regard to this patient and the patient's fitness for duty and ability to return to work at this time.

Health Care Provider Signature: Date:

Health Care Provider Information

Health Care Provider Name (please print):	
Address:	
City, State, Zip:	
Telephone:	Field of Specialty: