TOWN OF GLASTONBURY

RETURN TO WORK POLICY

The Town of Glastonbury requires the completion of this form for employees who have suffered a work/non work – related injury, or who have had a serious health condition as defined by the Family and Medical Leave Act. We are also concerned about the well-being of our employees. Therefore, in line with the *Return-To-Work Program,* this form must be completed by a medical physician before an employee can be permitted to return to the workplace.

GINA Regulation Compliance

"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 than 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."

PATIENT'S NAME _____Date _____
Patient's Job Title _____

Attending Physician's Name _____

NATURE: _____ Injury _____Illness _____Disability

Describe:

_____
_____
_____

EXAMINATION:

The employee was most recently examined by me on _____ the examination included:
Date

( ) X-Rays (Describe, if applicable)

_____
_____

( ) Physical Tests (Describe, if applicable)

_____
_____

( ) Other (Describe)

_____
_____

DIAGNOSIS:

_____
_____

TREATMENT:

If medication is prescribed, based on the attached job description, will it impair the employee's ability to perform the duties of his or her position: ( ) Yes (if yes, please explain) ( ) NO

_____

How long is the employee expected to be taking this medication

_____

_____

How long after the employee is no longer taking this medication will it have an impact on his/her ability to perform the duties of their position?

_____

_____

PROGRESS:

( ) Very Good ( ) Good ( ) Fair ( ) Slow ( ) Poor ( ) Erratic

( ) Improving as expected ( ) Steady Progressive Improvement

( ) Improvement Impaired due to:

_____

_____

STATUS: Based on the attached job description, please provide as much detail as possible:

( ) Employee may return to regular duty with no restrictions on _____.
Date

( ) Employee is fully disabled and unable to return to work at this time. Explain why.

_____

_____

In your medical opinion, how long is this disability expected to last? _____

When do you anticipate the employee will be able to return to work? _____

If indefinite, please explain_____

_____

_____

( ) Employee may return to work on _____ with restrictions. The individual must not be allowed to perform work which requires the following:

( ) Driving Equipment/Vehicle
( ) Working on/near moving machinery
( ) Working with chemicals
( ) Working with heavy equipment
( ) Excessive sitting
( ) Excessive bending
( ) Excessive standing
( ) Wearing a respirator
( ) others_____

( ) Lifting (Weight limit _____Lbs.
( ) Repetitive hand/arm movements
( ) Repetitive foot/leg movements
( ) Getting _____area wet
( ) Working more than _____hours
( ) Working in high noise area
( ) Working around unprotected heights
( ) Walking
( ) _____

These restrictions will be in affect from _____ through._____

Conclusions/Remarks: _____

_____

Please note that you may be asked to give testimony and/or submit documentation concerning the information that you have provided above to a physician representing the Town for review.

Physician's Signature_____ Date _____