TOWN OF GLASTONBURY

FIT FOR DUTY EVALUATION FORM

The policy of the Town of Glastonbury is to provide a safe work environment for its employees. Also, the town is concerned about its employee's wellbeing and their fitness for duty. As such, please evaluate this employee as following for his/her fitness for duty based on the attached job description. All information provided will be kept confidential. Please return to the Town of Glastonbury Human Resources Department at 2155 Main Street, Glastonbury, CT 06033.

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."

Employee's name _____Date _____

Attending Physician's Name _____

NATURE: _____ Injury _____Illness _____Disability _____Other

Describe:

_____

_____

_____

EXAMINATION:

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

( ) X-Rays, MRI, EKG, etc…. (Describe – if applicable)

_____

_____

( ) Physical Tests (Describe) as related to employees ability to perform duties of position.

_____

_____

( ) Other (Describe)

_____

_____

DIAGNOSIS: (as related to individual's ability to perform duties of position)

_____

_____

TREATMENT: (If medications could impact/impair judgment or ability to perform job functions)

Effects of Medication on individual performance

_____

_____

Frequency of treatment(s)/Medication: _____

_____

Describe: _____

_____

PROGRESS: How is employee recovering?
( ) Very Good ( ) Good ( ) Fair ( ) Slow ( ) Poor ( ) Erratic
( ) Improving as expected ( ) Steady Progressive Improvement
( ) Improvement Impaired due to:

_____

_____

STATUS: Please provide as much detail as possible:
( ) Employee may perform his/her regular duties with no restrictions on _____.
Date
( ) Employee is fully disabled or the medications he/she is taking make him/her unable to perform his/her duties at this time. Explain why.

_____

_____

In your medical opinion, how long is this condition/medication expected to continue?

_____

When do you anticipate the employee will be able to return to performing all of the duties of his/her position?

_____

If indefinite, please explain_____

_____

( ) Employee may continue working 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 _____

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