**Fitness for Duty Guide**

The EEOC permits medical inquiries post-hire in certain [limited circumstances](https://www.eeoc.gov/laws/guidance/enforcement-guidance-disability-related-inquiries-and-medical-examinations-employees#4):

Generally, this indicates that fitness for duty tests or inquiries may be required when "job-related and consistent with business necessity", when an employer "has a reasonable belief, based on objective evidence, that:

(1) an employee's ability to perform essential job functions will be impaired by a medical condition; or

(2) an employee will pose a direct threat due to a medical condition.

Often an ADA Reasonable Accommodation Form is more appropriate for the following inquiries. We do not suggest using a Fitness for Duty form in this case:

* When you have evidence of a disabling condition and there also is evidence that the condition is causing the employee to be unable to accomplish the essential functions of their job.
* When an employee’s behavior is causing a direct threat to their safety or the safety of others and you have evidence that it is as a result of a medical condition.

A Fitness for Duty form is reasonable when an employee is returning from a personal medical leave of absence when their physician has already taken them out of work, since it is clear that the employee may not be able to perform their job due to a medical condition.

This form will often require a follow-up Reasonable Accommodation form OR other requests for suggestions of reasonable accommodations. Leave as well as other accommodations may be employed to continue someone’s employment even if they are not initially seen as capable of returning, under the ADA.

In some cases, if you already have evidence due to Workers Compensation or FMLA information that the employee has an ongoing disabling condition and you may choose to reasonably accommodate leave, for example, simply on the basis of this fitness for duty form.

Contact Catapult if you plan on using this form for other purposes.

***This form and guide have been reviewed for NC/SC laws only.***

**Fitness for Duty Form**

You are required to provide this fitness for duty certification along with the enclosed job description to the treating physician who is knowledgeable regarding your ability to perform attached duties.

Submit the completed form to Human Resources within at least five business days after your medical examination is completed. Human Resources will then place this document in your confidential medical file.

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Leave: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected Return Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To be completed ONLY by the HEALTH CARE PROVIDER**

*(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).*

I have reviewed a job description of the above-named patient’s job duties. Yes No (Circle One)

I have examined the above named patient and certify that:

\_\_\_The patient is able to perform all of the duties of the position with no restrictions.

**OR**

\_\_\_The patient is able to perform job duties of the position with the following time, duty, or other restrictions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Expected duration of the restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

\_\_\_ The patient is not able to perform job duties at this time with or without restrictions. Please indicate the expected duration of leave without performing any duties (or follow-up date to check in with medical provider): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

\_\_\_ The employee will never be able to perform the essential functions of the position.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Health Care Provider Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Health Care Provider Name of Practice

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number