HAMILTON COUNTY SCHOOLS

RETURN TO WORK FORM

Employee Name: _____ Employee I.D.:_____

The above-mentioned employee may return to work on: _____/_____/_____

Does the employee have any current restrictions? _____ NO _____YES
If you marked **"YES" (regarding restrictions)** above, please review the attached job description and mark the appropriate box(es) for which the employee has restrictions. Feel free to make comments as needed.

*****If the employee is not restricted in a specific area, please leave it blank.**

Activity	Mark box(es) below **ONLY** if restrictions apply.	Activity	Mark box(es) below **ONLY** if restrictions apply.
Lift/Carry		Twist/Turn	
5 lbs. or less		Climb	
6 – 10 lbs.		Crawl	
11 – 20 lbs.		Reach Above Shoulder	
21 – 50 lbs.		Reach Outward	
Push/Pull:		Stand	
5 lbs. or less		Walk	
6 – 10 lbs.		Sit	
11 – 20 lbs.			
21 – 50 lbs.		Drive	
Bend			
Squat/Kneel			

Restrictions will be in effect from: _____/_____/_____ to _____/_____/_____

Additional healthcare provider comments: _____

_____

_____

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 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 reproductive services." 29 C.F.R. §1635.8(b)(1)(i)(B) **Please be advised that GINA Title II does allow you to provide information about the medical condition of an employee's spouse, parent or child to certify the need for leave under the Family and Medical Leave Act (FMLA).**

Healthcare Provider Name _____

Address: _____

Telephone: _____ Fax: _____

Signature of examining healthcare provider_____ Date: _____/_____/_____

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Fax completed Return to Work form to Cathy Hendricks, Human Resources at (423) 498-6680. If you have any questions regarding form, call (423) 498-7068 or e-mail hendricks_cathy@hcde.org.