EMPLOYEE NAME: ________________________________

FITNESS FOR DUTY TO RETURN FROM LEAVE CERTIFICATION

An employee on Family and Medical Leave[1] because of his/her own serious medical condition must present this release to his/her supervisor prior to or on the day he/she returns to work. An employee may not work without this release.

Please complete and return form to TRISTAR Benefit Administrators via fax at 562-495-6687

TO: Health Care Provider

Your patient, ____________________________________, began a period of medical care leave for his/her serious health condition on ________________________.
date employee commenced leave)

As a condition of return to work, the employee must have a medical examination. This form must be completed by you, as his/her health care provider, before the employee is allowed to resume his/her job duties.

1. Employee Name: ____
2. Employee's Job Title: _____________________________________
3. Date of Medical Examination: ______________________________
4. Date employee may return from leave _____________________________________.
5. Please indicate with a check mark the status of the employee's release for duty.

   ______________ Full, unrestricted duty. (Skip question 6 and proceed to item 7.)
   ______________ Modified duty. (Complete question 6.)
   ______________ Not released for any type of duty. (Go to item 7.)

6. If you are releasing the employee to modified duty, you must complete the following:

   a. Estimated date that employee will be able to return to full, unrestricted duty: _______________________________________.
   b. Date of your next medical evaluation of the employee: ______________________________________.
   c. Indicate the exact work restrictions which apply to the employee at this time on the chart on page 2 of this form.

[1] Refers to both Federal and State Leaves under the Family Medical Leave Act and the California Family Rights Act.

EMPLOYEE NAME: ___________________________________

(Complete this section if the employee is being released to modified duty.)

PHYSICAL EXAMINATIONS	FULL RESTRICTIONS	PARTIAL RESTRICTIONS	NO RESTRICTIONS
Sedentary-Lifting 0 to 10 pounds			
Light-Lifting 10 to 20 pounds			
Moderate-Lifting 20 to 50 pounds			
Heavy-Lifting 50 to 100 pounds			
Pulling/Pushing, Carrying			
Reaching or working above shoulder			
Walking (hrs)			
Standing (hrs)			
Sitting (hrs)			
Stooping (hrs)			
Kneeling (hrs)			
Repeated Bending (hrs)			
Climbing (hrs)			
Operating a motor vehicle, crane, tractor, etc.			
Other:			
Exposure Limitation (Specify):			

7. I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury at __________________________, this ______ day of ___________________, ___.
(List City and State) (month) (year)

_______________________________________ _______________________
Signature of Health Care Provider Date

_______________________________________ _______________________
Print Name of Health Care Provider Phone Number

__________________ __________________
Type of Practice License No.

____
Address

____
City State Zip

The Genetic Information Non-Discrimination 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's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.