

## EMPLOYEE:

M

## Return completed form to employer prior to returning to work

Tacoma Community College - 6501 S 19th St, Tacoma, WA 98466 | Fax: 253.566.5374 | Email: humanresources@tacomacc.edu

If restrictions are identified by the medical provider, the College will determine (based upon the information provided) whether light duty is available. Employees are not to return to the workplace until HR in conjunction with the supervisor makes this determination.

## EMPLOYEE INFORMATION AND INFORMED CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Employee Name:			
Address:			
Telephone Number:			
y normal work schedule is:	Monday Hours	Tuesday Hours Wednesday Hours	
,	Thursday Hours	Friday Hours	
	Total work hours per week:		

## Authorization to Release Information:

I hereby authorize my health care provider to release and disclose to Tacoma Community College, such health care records and information concerning my current medical condition as is necessary to determine my fitness for employment and/or return to work.

**Employee Signature** 

Date

STATEMENT OF PHYSICIAN OR PRACTITIONER (Please Print Clearly)					
Date patient was last examined:	Has patient reached the end of his/her treatment period?				
Is patient able to work his/her normal work schedule as shown above? Yes No					
If YES Please provide date the employee may return to full work schedule:					
If <b>NO</b> please identify the number of hours per day and the number of hours per week that the patient can work, and the expected duration of the period for the reduced schedule					
Monday Hours Tuesday Hours Thursday Hours Friday Hours Tot	Wednesday Hours al Maximum work hours for the week:				
The above modified schedule is needed from	(date) through(date)				
This modified schedule will be for an undetermined period. Next scheduled physician review for fitness for duty will be on:(date)					

After reviewing the patient's job description, would you place a job functions upon their return?	ny work restrictions	for the patient's performance of any	
No – This patient <b>can</b> return to work <b>without</b> restriction on		(date)	
Yes - If yes, please describe what restrictions apply below			
The following restrictions Apply:			
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers genetic information of employees or their family member. In order to comply with responding to this request for medical information. "Genetic information," as definindividual's or family member's genetic tests, the fact that an individual or an ind	this law, we are asking that ned by GINA, includes an inc	you not provide any genetic information when lividual's family medical history, the results of an	
Additional Comments:			
I certify that the above representations accurately reflect my in the patient's fitness for duty and ability to return to work at this	•	ion with regard to this patient and	
Health Care Provider Signature		Date	
PHYSICIAN OR PRACTITIO			
Physician Name	MER INFORMATION		
Address			
City	State	Zip Code	
·			
Telephone	Field of Specialty		