FITNESS FOR DUTY CERTIFICATION (MD 201)

TO BE COMPLETED BY THE EMPLOYEE

Employee's Information:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
ID No: _____ Phone No: _____
Position: _____ Dept: _____
Safety sensitive? _____ Yes _____ No

Physician's Information:

Name: _____
Address: _____
_____
City: _____ State: _____ Zip Code: _____
Phone No: _____ Fax No: _____

The provider named above is authorized to provide the IHB RR and/or its MRO any and all medical records regarding my illness or injury as it relates to my absence from work. I authorize the IHB RR and/or its MRO to contact the provider if further information is required.

_____ _____
Employee Signature Date

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

_____Yes _____No I have received and reviewed a copy of the IHB's functional job description for this employee's position prior to rendering this opinion. (If you would like a copy sent to you, please call 219-989-4850 or email melanie.lindner@ihbrr.com)

_____ The above named employee may return to work without any restrictions on _____ (date).

_____ The above named employee may return to work with the following restrictions: on _____ (date).

_____ No lifting over _____lbs. _____ No repetitive kneeling, squatting _____ Must wear hearing protection

_____ No repetitive stooping, twisting _____ No prolonged standing, walking _____ Other, please list below

The above named employee may not return to work at this time. (Please list reasons below)

If the employee's position has been designated as safety sensitive above, the employee has _____ has not_____ been prescribed other than over the counter drugs. (If so, please complete safety sensitive drug report (MD1000))

Comments, other work restrictions, drug treatments (required), etc.: _____

_____ _____
Provider's Signature Date

TO BE COMPLETED BY THE IHB MRO

_____ The above named employee may return to work without any restrictions on _____ (date).

_____ The above named employee may return to work with the following restrictions:

_____ No lifting over _____lbs. _____ No repetitive kneeling, squatting _____ Must wear hearing protection

_____ No repetitive stooping, twisting _____ No prolonged standing, walking

_____ The above named employee may not return to work at this time. (Please list reasons below)

Comments: _____

_____ _____
IHB Medical Review Officer's Signature Date

NOTE: IHB's Medical Director may use IHB Form MD-100 for more detailed restrictions, etc. Same should accompany this form.

Return this form to the IHB Human Resources Department, 2721-161st Street, Hammond, IN 46323-1099, or fax this form to 219-989-4967.