FITNESS FOR DUTY CERTIFICATION

SSA EMPLOYEE:

You are being requested to provide a completed fitness for duty certification prior to returning to work from your extended (3 or more days) medical absence. Once completed, the document must be submitted to Human Resources at least two business days prior toyour return to work.

This document must be completed by the health care provider who has been treating you for your medical condition whichrequired the extended absence. This form can be faxed to (877) 720-8701 or emailed to hr@statesecurityagency.net

EMPLOYEE INFORMATION AND INFORMED CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION		
Name		
Address		Telephone
City	State	Zip Code

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the physician or practitioner identified below to release and disclose to State Security Agency or its employees or representatives of such healthcare records and information concerning my current medical condition as is necessary to determine my fitness for employment and/or eligibility for any employer-provided benefit. This authorization shall be valid for two (2) years from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation will not apply to any information that has already been released in reliance on this authorization, and that any revocation may have an adverse effect on the receipt of employer-provided benefits.

Employee Signature: Date:

PHYSICIAN OR PRACTITIONER:

STATEMENT OF PHYSICIAN OR PRACTITIONER
Date on which patient can return to work: / /
After reviewing the patient's Essential Job Functions attached to this form, is the patient able to work his/her normal work schedule? Yes No If not, 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 through the requested activity information below:
Describe any restrictions that may apply to the patient's work other than what is requested in the activity list below (see Essential Job Functions document):

Please indicate below the patient's ability to perform the following tasks continuously or intermittently, and give the numberof hours per day they may perform each task:

ACTIVITY	CONTINUOUS	INTERMITTENT	#HRS/Day
1. Lifting/ Carrying: (State Max. Weight)	#Lbs.	#Lbs.	
2. Sitting			
3. Standing			
4. Walking			
5. Climbing			
6. Kneeling			
7. Bending/Stooping			
8. Twisting			
9. Pulling/Pushing			
10. Simple Grasping			
11. Fine Manipulation (includes keyboarding)			
12. Reaching above Shoulder			
13. Driving a Vehicle (Specify) ifapplicable to the position?			-
14. Traveling			
15. Safe handling of any equipment, material or vehicle thatmay be required in performing job duties? ifapplicable to the position?			
	Please comment on any specific concerns or limitations in relation to the essential functions of the position.		
16. Is the employee able to perform the essential job functions of the position, which may include understanding; remembering; sustained concentration; accurate awareness of the environment; follow-through on instructions; decision making?			
17. Is the employee able to perform the essential job functions of the position, which may include ability to receive supervision; manage ambiguity; tolerate stress; maintain composure; relate to coworkers and customers?			

18. Is the employee able to return to work without posing a significant risk or substantial harm to him/herself or others?	

I hereby certify that the facts in this document are true and correct.

PHYSICIAN OR PRACTITIONER INFORMATION		
Physician Signature		Date/
Physician Name		Type of Practice
Address		Telephone
City	State	Zip Code