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: _____
Is your position safety sensitive? Yes _____ No _____

Physician's Information:

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

I authorize the IHB to contact the above provider to obtain clarification regarding the responses provided on this form and/or to discuss my health condition as it relates to my ability to safely perform my safety sensitive job duties only. YES _____ NO _____
I authorize the above provider to speak with the IHB regarding this form and my health condition as it relates to my ability to safely perform my safety sensitive job duties only. YES _____ NO _____

_____ _____
Employee Signature Date

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

The above listed employee has been under my care for the following illness/injury: _____

The below recommendation is my medical opinion based on the following:

- □ My review of the IHB's functional job description for the employee's position.
  (You may obtain a copy of the employee's functional job description by calling 219-989-4923 or by emailing HR@ihbrr.com)
- □ The employee's description of their job duties.

To my knowledge, the employee (□ does/ □ does not) perform safety sensitive job duties.

Upon review of the employee's job duties, my examination of the patient, and my medical knowledge and experience, the following is my recommendation regarding the employee's return to work; (please select the appropriate statement and answer all accompanying questions)

□ The employee may return to work with no restrictions.

Employee is released to return to work on _____ (mm/dd/yyyy).

Employee (□ has/ □ has not) been prescribed medication (other than over-the-counter) which they will continue to take upon their return to work.
(If medication has been prescribed and employee's job is safety sensitive, form MD1000 is required)

□ The employee may return to work with the following restrictions.

- □ No lifting over _____ lbs.
- □ No repetitive bending/twisting
- □ No repetitive kneeling/squatting
- □ No prolonged standing/walking/sitting
- □ Must wear/use special equipment/protection
- □ Other

Please explain any/all restrictions that apply to this employee: _____
_____
_____

Employee (□ has/ □ has not) been prescribed medication (other than over-the-counter) which they will continue to take upon their return to work.
(If medication has been prescribed and employee's job is safety sensitive, form MD1000 is required)

□ The employee may not return to work at this time.

Please provide an estimate of when you anticipate that the employee will be able to return to work and the ongoing treatment/recovery required. _____
_____

Please provide any additional comments or information relevant to the employees fitness for duty:

_____ _____
Provider's Signature Date

NOTE: IHB's Medical Consultant may use IHB Form MD-100 for more detailed instructions/restrictions regarding their RTW exam.

Return this form to the IHB Human Resources Department, 2721-161st Street, Hammond, IN 46323-1099, or fax this form to 219-989-4890 or email to doctors.note@ihbrr.com.