



Clayton County Public Schools
Division of Human Resources and Strategic Improvement
MEDICAL RELEASE INTENT TO RETURN TO WORK
AND FITNESS FOR DUTY

SECTION I – To be completed by EMPLOYEE/PATIENT

First Name _____ MI _____ Last Name _____

Phone Number _____ Personal Email Address _____

I authorize the health care provider identified for determining my fitness for duty. In addition, I authorize a designated CCPS Human Resources professional to contact the health care provider to authenticate and/or certify the information if needed. I understand that if I do not agree to this authorization, my return to work may be delayed or denied, which may result in termination of employment.

Employee's Signature: _____ Date: _____

An employee who fraudulently obtains Family Medical Leave will be subject to disciplinary action, up to and including termination.

SECTION II – Instructions for EMPLOYEE

SECTION III: To be completed by HEALTH CARE PROVIDER

Name of Health Care Provider _____

Address _____

Phone Number _____

PLEASE COMPLETE THE FOLLOWING AND RETURN THE FORM TO THE EMPLOYEE/PATIENT OR TO THE DEPARTMENT CONTACT LISTED BELOW PRIOR TO THE RETURN TO WORK DATE

Important: Please limit your answers below to the serious health condition for which the Employee has been on leave.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): The Genetic Information Nondiscrimination 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 or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. **Is the employee now able to perform those essential functions of his or her job that could not previously be performed because of the serious health condition for which the employee has been on leave?**
 No Yes Yes, with restrictions
2. **Employee released to return to work effective:** _____ [Indicate date]
3. **If the employee is released to work but is restricted in his or her ability to perform the essential functions of his or her job as a result of the serious health condition for the employee has been on leave, please describe those restrictions:**
4. **The forgoing restrictions are**
 Permanent
 Temporary, until _____ [Indicate date]

Print Health Care Provider Name _____

Health Care Provider Signature _____ Date: _____

Return completed form to: Clayton County Public Schools Division of Human Resources and Strategic Improvement Department at 1058 Fifth Avenue Jonesboro, GA 30236 or email to FamMedLeave@clayton.k12.ga.us

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