Airswift Fitness for Duty Notice & Instructions

Return to Work Policy: All employees must be referred to the Benefits and Safety Department for a Return to Work Physical Examination Request in each of the following instances:

A. If the employee is returning to work after an absence of thirty days or more (other than vacation); or
B. If the employee has suffered an on-duty injury
C. If the employee has undergone surgery or a medical operation; or
D. If the employee has been hospitalized for any reason; or
E. If the employee has suffered an off-duty injury

Form to be completed by a health care provider: An employee on a medical leave for any of the above, needs to present this Fitness for duty form in full completion to their Airswift Service Consultant prior to returning to work.

Instructions for Completion:

Part 1 to be completed by Employee
Part 2 – 6 to be completed by Physician

Health Care Professionals: Your patient has three return to work options:

Full Release: The patient has no work restrictions. The patient can return to his/her prior position because you, the health care provider certifies, that he/she can perform the essential functions on the job.

Modified Duty: The patient has some work restrictions. Work restrictions must be specifically notated on the following page. Each modified duty work restriction request will be reviewed carefully to determine if the employee can perform the essential functions and return to work.

Not Released: The patient is not released to work in any capacity due to physical or behavioral limitations.

GINA Instruction: 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.

Confidentiality Notice: All information on this form, including any supporting medical documentation, shall be maintained in separate files and shall be treated as confidential medical records under GINA and the Americans with Disabilities Act of 1990, as amended (ADA). Under the ADA, this information may be disclosed to management personnel who need to be informed of any work restrictions and accommodations, first aid personnel (when appropriate), and government officials investigating compliance with the ADA, FMLA or other applicable law.

Submission: The Fitness for duty Form can be submitted confidentially to:

Attention to Safety & Benefits Department
Email: usincidents@airswift.com & benefits@airswift.com
Phone Number: 832-942-2010

Job Function Analysis for Fitness for Duty Evaluation

Note: This form should be completed by the Service Consultant with input from a supervisor, manager or the Client as needed. After this form is completed, it should be provided to the employee who should deliver this form, along with the job description to the medical provider performing the Fitness for Duty Evaluation.		
Candidate Full Legal Name		
Job Title/Position		
Description of Duties (Attach complete job description if available) ☐ Job Description Attached		
Work Location (including country)		
Essential Functions for the Position		
☐ Below Waist Lifting (___ lbs)	☐Above Waist Lifting (___ lbs)	☐One Hand Carrying (___ lbs)
☐ Two Hand Carrying (___ lbs)	☐ Pushing-Max Force (___ lbs)	☐ Pulling-Max Force (___ lbs)
☐ Sit, Stand, Kneel, Squat (___ hrs)	☐ Reaching (High Level / Low Level)	☐ Walking (>____ ft. / miles)
☐ Climbing Ladder (___ Rungs per day)	☐ Climbing Stairs (__ Steps per day)	☐ Jumping (> ___ ft. ___ Repetitions)
☐ Body Twisting/ Static (_____)	☐ Throwing (___ lbs, ____ ft.)	☐ Lift From Floor & Carry Task (___ lbs. for ___ ft. for ___ Repetitions)
☐ Balancing (Ability to maintain bodily equilibrium and stability on level or uneven surfaces)	☐ Sense of Smell (Perceiving odors or scents that could indicate harmful environmental exposure)	☐ Speaking Clearly (Ability to communicate over substantial background noise)
☐ Seeing at a Distance (See objects > ___ ft. away)	☐ Seeing - Near (See objects < ___ inches / feet away)	☐ Color Vision _____ (Ability to distinguish different colors)
☐ Depth Perception (Ability to judge distances and spatial relationships.)	☐ Hearing - Speech Range/All (Ability to hear all sounds made by the human voice as well as human hearing)	☐ Other
Other Relevant Functions (e.g., critical thinking, meeting deadlines, etc.), Information or Circumstances:		
Form Completed By (Name):		
Title/Position:		
Signature:		

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Airswift Fitness for Duty Form

PART I. EMPLOYEE INFORMATION	
Employee Name:	Phone Number:
Last 4 Digits of SSN (to confirm identity): XXX-XX-	Work Location (City, State, Zip Code):
Title / Position:	
Employee Authorization: I HEREBY GIVE MY CONSENT to the healthcare provider listed below permission to disclose my medical information by answering the questions contained in this questionnaire. I authorize disclosure of this information Airswift, and its authorized employees, representatives, and agents.	
Employee Signature:	Date:

PART II. PROVIDER INFORMATION	
Name of Treating Physician:	Specialty of Treating Physician:
Clinic / Facility Name:	Clinic / Facility Address:
Clinic / Facility Phone Number:	Fax Number:

PART III. INFORMATION RELATING TO EMPLOYEE'S HEALTH CONDITION

Date Patient was Last Examined: _____.

I have reviewed my patient's job description and I can attest that the patient is:

- **Fully Released** - Able to return to work and perform his/her duties with no restrictions effective_____.
- **Modified Duty** - Able to return to work and perform his/her duties with restrictions listed below effective _____.
- **Not Released** - Is not released for any type of duty. Next evaluation date will be on _____.

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PART IV. RESTRICTIONS / ACCOMODATIONS		
List Restrictions Below	**Start Date**	**Next Evaluation Date**
Ex: Patient cannot work more than 4 hours per day and/or on a particular shift for two weeks	1/1/1999	1/15/1999
1.		
2.		
3.		
4.		

PART V. ADDITIONAL INFORMATION

Is the patient taking any prescription medications that impair his/her abilities to perform his/her work or any other independent tasks (like driving) safely?

☐ No

☐ Yes

If yes, please explain:

_____

_____

_____

Any additional comments or concerns that should be addressed:

_____

_____

_____

PART VI. PHYSICIAN SIGNATURE

Physician Authorization: I HEREBY CERTIFY that the information on this form is true and correct.

Physician Signature:	Date:

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