CITY OF ALABASTER
RETURN TO WORK CERTIFICATION

SECTION I – To be completed by THE EMPLOYEE

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)

EMPLOYEE'S DEPARTMENT AND POSITION

SECTION II – To be completed by HEALTH CARE PROVIDER

NAME OF HEALTH CARE PROVIDER

ADDRESS	TELEPHONE NUMBER OF HEALTH CARE PROVIDER

PLEASE COMPLETE THE FOLLOWING AND RETURN THE FORM TO THE EMPLOYEE OR FAX TO THE CITY OF ALABASTER PERSONNEL DEPARTMENT AT (205) 664-6853

Important: Please limit your answers below to the 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 able to return to full duty and perform the essential functions of his or her job?

   ☐ Yes. (answer item # 2, below)
   ☐ Yes, with restrictions (answer items # 2, 3, and 4 below)
   ☐ No. (answer item # 5 below)

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, please describe those restrictions:

4. The foregoing restrictions are:

   ☐ Permanent
   ☐ Temporary, until: ________________________ *[indicate date]*

5. Please provide the Employee's debilitating diagnosis or symptoms, the regimen of continuing treatment, and the estimated end date for the period of incapacity.

SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER	DATE