Department of Administrative Services
Empowering People Collaboration Customer Service

STATE OF IOWA RETURN TO WORK CERTIFICATION

Section 1: Instructions for the EMPLOYEE:

Retrieve a copy of your essential job functions from your supervisor.

You are required to have a return to work certification completed by the health care provider who has knowledge regarding your reason for using leave. You must submit the completed form, to your agency human resources or supervisor, prior to your return to work or your return to work may be delayed or denied.

Employee Name (print): _____ Supervisor: _____

Department: _____ Date Leave Began: _____ Expect Date of Return: _____

☐ Yes I intend to return to work as scheduled.
☐ No I do not intend to return to work as scheduled

By signing below, I authorize the health care provider identified below to provide the information requested on this form for the purposes of determining my ability to return to work.

Employee's Signature: _____ Date: _____

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

Section 2: To be completed by the HEALTH CARE PROVIDER:

This certification is being sought only with regard to the particular health condition that caused the employee's need for leave.
Instructions to the Health Care Provider: Please review the employee's work schedule and essential functions (attached) and answer the following:

☐ Yes ☐ No I have reviewed the essential functions of the above named patient's job.

I have examined the above named patient on: _____(date)

☐ The employee is **not** released to return to work.

☐ I certify that, with regard to the particular health condition that caused the employee's need for leave, the employee is fit for duty and able to resume to work as follows:

☐ Full/unrestricted duty, effective:_____(date)

☐ Restricted duty, effective:_____(date) Date of next medical evaluation:_____(date)
Indicate the exact work restrictions and list the essential functions the employee is unable to perform:

_____

_____

Health Care Provider Information:

I hereby certify that I have examined the employee named above, and declare that the statements made in this Fitness for Duty Certification are true and correct.

Signature: _____ Date: _____

Printed Name: _____ Phone Number: _____

Address:_____ Type of Practice/Specialty: _____

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 DISCLOSURE

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 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 individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.