

Request for Fitness for Duty Examination

Requests for fitness for duty examinations will be job related and consistent with business necessity and will only be initiated when there is **reasonable belief, based on objective evidence, that due to the employee's medical or mental health condition, the employee will be unable to perform essential job functions or will pose a direct threat to the health and safety of self and others.**

To be completed by the facility/unit head making this request:

Name of Facility/Unit: _____

Name of Affected Employee and Job Title: _____

Describe the reason/circumstances requiring a fitness for duty inquiry (attach copy of any incident report):

The reasons/circumstances described above indicate that:

- Yes No The employee will be unable to perform essential job functions due to a medical/mental health condition; or
- Yes No The employee will pose a direct threat due to a medical/mental health condition (Section II. must also be completed)

I. Reasonable Belief and Evidence Relied Upon:

Complete either Section I. A. items 1. and 2. or Section I. B. items 1. and 2.

A. Employee's Known Medical/Mental Health Condition and Related Performance/Conduct Problems

1. Known Medical/Mental Health Condition

a. Describe the employee's known medical/mental health condition:

b. Evidence of medical/mental health condition (please check all that apply):

- The employee has disclosed this medical/mental health condition to me.
- I learned about this medical/mental health condition due to reliable information provided by a credible person. If yes, provide the **name(s) of person(s)** and describe the **reasons** you believe this information is reliable (i.e. relationship of person to employee, how person learned of the information, seriousness of the medical/mental health condition, possible motivation of person providing the information, any other evidence relied upon):

This completed form contains confidential medical information and will be maintained in the employee's medical file.

Name of person: _____

Reasons to believe information is reliable: _____

2. Performance/Conduct Problems

___Yes ___No

The employee has recently exhibited performance or conduct problems. If yes, complete the remainder of this section. Describe the problems: _____

What evidence or documentation exists regarding the described performance or conduct problems?

Why do you attribute the performance or conduct problems to the medical/mental health condition?

B. Unknown Medical/Mental Health Condition (Observable Symptoms of Medical/Mental Health Condition) That Will Impair Job Performance or Pose a Direct Threat

1. Unknown Medical/Mental Health Condition

a. Describe the observed symptoms that indicate the employee may have a medical/mental health condition:

b. Evidence of medical/mental health condition (please check all that apply):

___ I have directly observed the above-listed symptoms

___ The symptoms have been reported to me by a credible person

Name of person: _____

Reason(s) to believe information is reliable: _____

2. Reasonable Belief the Employee Will Be Unable to Perform Essential Job Functions or Will Pose a Direct Threat

a. Impairment of Ability to Perform Essential Job Functions

___ Yes ___ No

The employee's ability to perform essential job functions will be impaired due to a medical/mental health condition. If yes, complete this section. List the essential job functions that will be impaired:

(Attach the applicable job description and the PMP accountabilities)

II. Direct Threat Posed by Employee

___ Yes ___ No The employee will pose a direct threat to the health or safety of themselves or others due to a medical/mental health condition. If yes, complete this section. Describe the direct threat that will be posed:

III. Request Authorization for Action: (√ all that apply)

- ___ Require employee to provide documentation from their medical/mental health care provider regarding fitness for duty;
- ___ Order employee to report for fitness for duty exam with department selected medical/mental health care provider for direct threat assessment (Section II. must be completed)
- ___ Temporary modification of job duties pending completion of FFDE
- ___ Temporary absence from work pending completion of FFDE
- ___ Due to the immediate safety threat, the following actions have already been taken:

Signature of Facility/Unit Head

Date

Signature of Division Head

Date

To Be Completed By chief administrator of Human Resources

IV. Authorization

The following actions have been authorized: _____

Authorizing Signature

Date