Employee Name:

Employee Id:

Case Number:

sedgwick®

Phone: (866) 431-8484

Fax: (855) 259-2246

Luxotticaleaveforms@sedgwick.com

Fitness for Duty Certification

This Fitness for Duty Certification must be completed by your Health Care Provider and submitted to your manager or Human Resources Business Partner upon your return to work.

This section is to be completed by the EMPLOYEE	
Employee Name:	Luxottica ID:
Brand :	
	Return to work Date:
I understand that I cannot return to work without a release from my health care provider.	
Employee's Signature:	Date:

This section is to be completed by the HEALTH CARE PROVIDER
Your patient has been on leave due to a serious health condition and/or other medical condition. Please answer, fully and completely, all applicable parts of this certification form. Your answers to the questions below should be limited to the condition for which the employee has been on leave. In other words, the certification should certify whether the employee is able to return to work and can perform the essential functions of his or her job as they relate to the employee's condition that necessitated the leave. The Genetic Information Nondiscrimination Act of 2008 (GINA), as well as the California Genetic Information Nondiscrimination Act of 2011 (CalGINA), prohibit employers and other covered entities from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with the law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by law, includes an individual's family medical history, information regarding the manifestation of a disease or disorder in an individual's family member, 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 or participated in clinical research that includes 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. "Genetic information" does not include information about the individual's sex or age. **PLEASE *DO NOT* STATE OR IN ANY WAY INDICATE THE SPECIFIC NATURE OF THE HEALTH OR MEDICAL CONDITION OR DIAGNOSIS ANYWHERE ON THIS DOCUMENT WITHOUT THE PATIENT'S CONSENT.**
I have examined the employee named above and certify that this person is **medically able to resume working on** (enter date here):
This employee can return to work: ☐ Full-time Duties, With No Restrictions ☐ Full-time Duties, With Restrictions (outline details below) ☐ Part-time Duties, With No Restrictions (outline details below)

☐ Part-time Duties, With Restrictions (outline details below) ☐ Intermittent Duties, With Restrictions (outline details below)	
Please state in detail the employee's restrictions and the duration of the restrictions:	
Signature of Health Care Provider:	**Date:**
Name of Health Care Provider (Please Print):	
Address of Health Care Provider:	
Phone Number of Health Care Provider:	