**Please fax this form to 410-955-1617.**

Johns Hopkins
Occupational Health
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410-955-6211 / FAX 410-955-1617

# Evaluation for Work Clearance Form

## Section I: Employee Information.

Employee Name: ____________________ Date of Birth: ____________

*The above employee is being evaluated for a job related screening at Johns Hopkins Occupational Health.*

The employee reports the following health information: ____________________

## Section II: Health Information must be completed by Health Care Provider:

**1.** DIAGNOSIS/ES per provider: ____________________

**2.** Medication/s being taken for this medical condition/s: ____________________

**3.** Is this medical condition permanent or chronic? **Yes** ☐ **No** ☐ **4.** Date of next Evaluation: ____________

## Section III: Work Clearance must be completed by Health Care Provider:

**After reviewing the attached job description (essential job functions) please complete (A), (B), or (C) as needed:**

☐ **(A). The employee can return or start work full duty without restrictions on ____/____/____(date)*.**

***<u>THE EMPLOYEE CAN PERFORM ALL ESSENTIAL JOB FUNCTIONS</u>. Proceed to Section IV.**

☐ **(B). The employee is estimated to need to be off work for his/her health condition until ____/____/____(date).**

☐ **(C). The employee can return to or start work with the following restrictions to start on ___/____/___ (date) to last until ____/____/____ (date).**
**<u>Only</u> if restrictions are needed for the employee's health condition.**

**The restrictions are (Please check/complete <u>ONLY</u> the appropriate box/spaces):**

### Activity Restrictions:

| **MAXIMUM MINs PER HOUR able to perform each activity or use of affected body part/s per hour.** ***O mins means u/a to perform.*** | **0 mins* Fully Restricted** | **15 Mins** | **30 mins** | **45 mins** | **60 mins Not Restricted** |
|---|---|---|---|---|---|
| Standing | ☐ | ☐ | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ | ☐ | ☐ |
| Squatting/Kneeling | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bending (at waist) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Twisting (at waist) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Use of hands/wrists. R, L, or Both. *(Circle Affected area.)* | ☐ | ☐ | ☐ | ☐ | ☐ |
| Keyboarding/Repetitive Hand Motions | ☐ | ☐ | ☐ | ☐ | ☐ |
| Use of arms/shoulders. R, L, or Both. *(Circle Affected area.)* | ☐ | ☐ | ☐ | ☐ | ☐ |
| Use of legs. R, L, or Both. *(Circle Affected area.)* | ☐ | ☐ | ☐ | ☐ | ☐ |
| Overhead lifting/reaching | ☐ | ☐ | ☐ | ☐ | ☐ |
| Climbing/Using Ladders | ☐ | ☐ | ☐ | ☐ | ☐ |

☐ **May not lift/carry objects more than _____ LBS.**

☐ **May not push/pull (force required) more than _______ LBS.**

### Miscellaneous Restrictions:

☐ Must wear a splint/cast/boot to ____________ during work hours.

☐ To walk with crutches/cane/scooter/walker or needs to use a wheelchair. *Please circle device needed..*

☐ No operating moving/heavy machinery or driving.

☐ To wear oxygen as follows: ____________

☐ No overtime work.

☐ To work part-time: ____ hours per day _____ days per week.

☐ Needs _____ minute breaks every _____ hour/s per each shift worked.

☐ Does the employee have limitations to the following: (Please circle yes or no).

Seeing: Yes or No Hearing: Yes or No.
Speaking: Yes or No. Breathing: Yes or No

PLEASE explain any <u>yes</u> answer/s: ____________________

**Comments/Other Limitations**: ____________________

## Section IV: Health Care Provider Information

**Signature of Provider:** ____________________ **Print name of Provider:** ____________________

**Date:** ___/___/___ **Phone Number:** ____________ **Fax Number:** ____________________

*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 request or 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.*

For OH Office Use Only: ☐ New Hire ☐ RTW NURSE INITIALS:_______ Revised 2/27/23