

## U.S. Occupational Health Resources

## EHS

## **Fitness for Duty Form**

f		I Health Resources	
Site: Ed Bluestein	Phone: 512-933-6443	prm to the employee's worksite) Fax: 512-933-6030	
Site: Oak Hill	Phone: 512-895-2900	Fax: 512-955-6050	
Site: Chandler	Phone: 480-814-3641	Fax: 480-814-3945	
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TO BE COMPLETED BY THE	<b>EMPLOYEE</b>		
	-		
Name:	Employee ID	D#: Shift:	
designates, and any insurance com	panies servicing NXP to release an	pational Health Resources (OHR), any consulting physiciand exchange information from my medical records pertain form must be received by OHR prior to my return-to-w	ing to the
Employee Signature		Contact # Date	_
TO BE COMPLETED BY THE L (1) Diagnosis:		POVIDER (LHCP)	
(2) This condition is:   Not		□ Work related	
		with NO RESTRICTIONS OR LIMITATION	
(4) Employee may return to w	ork on WITH RE	Date  ESTRICTIONS LISTED below fromto_ Date	
(5) WORK RESTRICTIONS: (Meek)	Date lost employees in manufacturin	Date ng work <b>12-hour shifts</b> , alternating between 36 & 4	Date 8 hours per
Lifting, maximum pounds hours / day		Squatting / kneeling / crawling (max.) hours / day	
Pushing / pulling, maximum pounds hours / day		Repetitive hand / wrist motion (max.) hours / day	
Repetitive lifting, maximum	pounds hours / day	Reaching above shoulder (max.) hour	s / day
Grasping / squeezing, maximu	m pounds hours / day	Sitting, no more than hours at a tin	ne
Repetitive bending / stooping	(max.) hours / day	Standing / Walking (max.) hours / day	
Must use durable medical equipment □ YES		□ NO	
If Yes, equipment type and ins	structions must be provided in o	comments.	
Must wear medical device at w  If Yes, device type and instruc		□ <b>NO</b> ments.	

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OTHER RESTRICTIONS / COMMENTS						
(6) MEDICA	CATION RESTRICTIONS:					
Has employ	loyee been prescribed medication(s) that may cause a possible w ss or mood altering)?	orkplace safety concern and / or a driving issue (e.g.				
	□ NO					
	U YES					
	Please list medication(s) and possible effects associated	with each:				
If YES, will t	vill the medication impact the employee's ability to work safely duri	ing working hours?				
	□ YES					
	□ NO					
	□ Advised to take alternate treatment while at work. Please describe:					
LHCP Nam	ame: LHCP Signatu	re:				
LHCP Pho	hone: LHCP Fax:					
Follow-up	up Appointment:	Today's Date:				

**GINA disclaimer:** We are asking that you <u>not</u> 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.

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