
808.32 FITNESS FOR DUTY EVALUATION

:1 OBJECTIVE:

To provide a policy for processing requests to assess employees' fitness to perform the essential functions of their job. This policy applies to all employees of the City, except for elected officials.

:2 AUTHORITY:

This procedure adopted by City Council August 9, 2004, Item A4.

:3 DIRECTION:

General Administration Department Director, Human Resources Division Manager, and Health & Safety Manager.

:4 METHOD OF OPERATION:

A. Definitions

Fitness for Duty Examination – A physical examination and/or psychological evaluation conducted by a licensed, qualified healthcare professional to assess an employee's fitness/ability to perform the essential functions of the employee's job.

B. Policy

An employee who demonstrates inability to consistently perform essential job functions because of possible physical or emotional issues may be required to submit to a Fitness for Duty Evaluation.

Fitness for Duty referrals may be made by any Division Manager or Office Director, or designee (hereinafter referred to as "authorized manager") having reasonable concern about an employee's fitness to perform. Refusal to submit to a Fitness For Duty Evaluation may result in disciplinary action, up to and including termination.

All medical costs pertaining to the referral will be the responsibility of the department or office ordering the testing.

The referral process is as follows:

1. The authorized manager shall first contact the Labor Relations Section/Human Resources Division (407) 246-2228 for guidance if there are performance or other potential disciplinary issues involved.
2. The authorized manager shall contact the Health & Safety Manager (407) 246-3676 and request a fitness for duty exam.
3. The Health & Safety Manager will contact the Florida Hospital Call Center and request an appointment.
4. The Florida Hospital Call Center will contact the Health & Safety Manager with the appointment time and location and will advise whether or not the

employee will need to bring any personal medical records to the appointment. The Health & Safety Manager will inform the authorized manager of the appointment and of all other pertinent information that may be needed.

Florida Hospital will contact the referring manager directly if unable to reach the Health & Safety Manager.

5. The authorized manager will give the employee a written directive to go to the appointment; the directive will include the following information:
 - a) The date, time and location of the appointment;
 - b) The Authorization to Release Medical & Psychological Information Form. This release must be executed by the employee prior to the appointment and must be faxed directly to the Florida Hospital Call Center (407-691-5449). Florida Hospital Call Center will forward the release to the medical/healthcare provider that will be performing the evaluation.
 - c) A list of any medical records the employee is required to bring to the appointment; and,
 - d) A statement that a failure to keep the appointment may result in disciplinary action up to and including termination.
6. Prior to the appointment, the authorized manager will FAX to the Florida Hospital Call Center (407-691-5449) a brief written description of the observed behaviors that lead to the referral along with a copy of the referred employee's current position description.
7. If the employee fails to appear for the appointment, The Florida Hospital Call Center will immediately notify (by the end of the next business day) the Health & Safety Manager; the Health & Safety Manager will then contact the authorized manager and the Human Resources Division.
8. If notified of a missed appointment, the referring manager shall contact the employee to determine the reason the appointment was missed. The manager may then take one of the following actions:
 - a) Contact the Florida Hospital Call Center to reschedule the appointment;
 - b) Refer the matter to the Human Resources Division and take appropriate disciplinary action, if warranted.
9. The initial medical/healthcare provider may refer an employee to other specialists for further evaluation. The Florida Hospital Call Center will notify the Health & Safety Manager of any additional appointments.
10. The medical provider will provide a written fitness for duty evaluation to the authorized manager and will forward the original of that evaluation to Florida Hospital Call Center for inclusion in the employee's medical file.
11. If the employee is fully cleared to return to work, the authorized manager will take appropriate action, either retaining or shredding the copy of the fitness for duty evaluation.

12. If the employee is returned to work with restrictions, the authorized manager will decide whether the employee can continue in his or her present position with or without reasonable accommodation. If the employee can continue, the manager will keep the Return to Work Form in the departmental personnel records.
13. If the employee cannot continue in his or her present position or is not cleared to return to work, the authorized manager will refer the matter, along with a copy of all relevant documents to the Human Resources Division Manager.
14. If at any time, the authorized manager or the Human Resources Division Manager needs additional clarification on the employee's medical status or restrictions, the Health & Safety Manager is to be contacted for assistance in obtaining this information.

:5 FORMS:

Authorization to Release Medical & Psychological Information Form.

:6 COMMITTEE RESPONSIBILITIES:

None.

:7 REFERENCE:

This procedure adopted by City Council July 28, 2003, Item A4; amended September 15, 2003; amended August 9, 2004, Item A4.

:8 EFFECTIVE DATE:

This procedure effective August 9, 2004

**AUTHORIZATION TO RELEASE MEDICAL AND PSYCHOLOGICAL
INFORMATION**

I hereby authorize Florida Hospital, Florida Hospital Centra Care and any physician or other person who has attended, examined, or furnished medical services to me to provide to the City of Orlando, any of its authorized representatives and any medical provider to whom I am referred any and all information with respect to any illness or injury, medical history, diagnosis, consultation, prescriptions, or treatments and copies of all hospital or medical records pertaining thereto, including but not limited to intake questionnaires, reports, x-rays, diagnostic tests, films, charts, and other documents of every kind and description including psychiatric reports and/or evaluations and drug or alcohol use information that relate to or effect my employment with the City.

In this regard, I further hereby authorize full and complete disclosure of the records of educational institutions, military agencies/units, U.S.Veteran's Administration, current and former employers or any other person or entity who has custody of records regarding my physical condition (including, but not limited to, workers' compensation records, disability pension application records, and long term disability application records) to furnish complete copies of all records of every kind or nature, including but not limited to reports, findings, charts, documents, x-rays, diagnostic tests, films and evaluations, concerning my medical history, diagnosis, treatment or care, to the extent it may effect my employment.

I understand that this information will be used by the City of Orlando solely for the employment purposes of making fitness for duty decisions, hiring, assignment and promotional decisions, reasonable accommodation decisions, disability pension and benefits decisions, workers' compensation decisions and decisions regarding discipline or termination of employment. A refusal to sign this authorization may result in adverse employment consequences.

I understand that I have the right to revoke this authorization. Such revocation must be made in writing and may result in adverse employment consequences.

A copy of this executed authorization shall be considered as effective and valid as the original. This authorization will remain in effect for five (5) years from date of execution or until five (5) years after termination of my employment with the City of Orlando and cessation of any benefit provided or funded fully or in part by the City of Orlando, whichever occurs later.

I HAVE READ AND UNDERSTAND THIS AUTHORIZATION FOR RELEASE OF INFORMATION.

Date _____

(Print) NAME OF PATIENT

(Signature) PATIENT

Employee ID number

Employee SSN number

Witness (printed name)

Witness signature