

**Aiken County  
Employee Health  
FITNESS TO WORK EVALUATION**

**Employee name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Medical Information Requested from:** \_\_\_\_\_

**CONSENT FOR THE RELEASE OF MEDICAL INFORMATION**

I hereby give **my** consent for the release of medical information to Aiken County Employee Health for the purpose of determining my fitness to perform the physical functions of the position stated below. I understand that I have the right to inspect and copy the information to be disclosed and that I **may** withdraw this authorization upon written notification at any time, except to the extent that action has been taken in reliance upon this authorization. I understand that this authorization shall expire, without my expressed revocation, 90 days from the date written below.

**Date:** \_\_\_\_\_ **Employee Signature:** \_\_\_\_\_

**Dear Health Care Provider:**

*The above named associate is being evaluated for fitness to work for Aiken County in the following position:*

*Please assess this person's ability to perform the physical functions stated on the attached job description and comment in the space below. I am especially concerned about the following:*

**Employee Health Nurse Signature:** \_\_\_\_\_

<b>Healthcare provider assessment:</b>	
<input type="checkbox"/> Fit for position	
<input type="checkbox"/> Fit for position with the following restrictions	
Standing Sitting Walking Limit:	Bend Stoop Squat Limit:
Push Pull Lift Limit:	Climb Reach Limit:
Driving/ Operating Equipment Limit:	Exposure to Heat/ Cold Limit:
Other restrictions:	
<input type="checkbox"/> Not fit for position	
<b>Comments:</b>	
<b>Physician Signature:</b>	