

FITNESS FOR DUTY

Employee Name (printed): _____

Under Health and Human Resources Administration (HRSA) requirements, all clinical staff must attest to their fitness for duty upon hire and at least every two years as part of Carolina Family Health Centers, Inc.'s credentialing review and extensions of privileges. A positive response to the questions above may require you to be further evaluated by your medical provider to certify that you do not have any mental health, cognitive, substance use, or physical conditions that would prevent you from performing the duties outlined in your job description. Failure to disclose conditions that could impact your ability to carry out your duties can lead to corrective action, up to and including termination. Please explain any "yes" answers in the space provided on this form or by attaching a separate sheet. This form is confidential and is kept in the employee's credentials file.

1. Do you presently have any physical, cognitive, or mental health condition that affects your ability to perform clinical or professional duties? ☐Yes ☐No

If yes, please explain: _____

2. Within the past two years, have you been treated in an inpatient or outpatient facility, or have you missed work because of any physical, cognitive, or mental health condition that affects your ability to perform clinical or professional duties? ☐Yes ☐No

If yes, please explain: _____

3. Are you currently engaged in the illegal use of drugs?

☐Yes ☐No

If yes, please explain: _____

4. Do you use any chemical substances that would in any way impair or limit the ability to practice and perform the function of the job with reasonable skill and safety?

☐Yes ☐No

If yes, please explain: _____

5. Do you have any reason to believe that you would pose a risk to the safety and well-being of patients?

☐Yes ☐No

If yes, please explain: _____

6. Are you unable to perform the essential function of your area of practice even with reasonable accommodations? ☐Yes ☐No

If yes, please explain: _____

7. Within the past five years, have you been treated in an inpatient or outpatient facility, or have you missed work because of a substance use disorder? ☐Yes ☐No

If yes, please explain: _____

8. Are you currently taking any medications that may affect your ability to perform clinical or professional duties? ☐Yes ☐No

If yes, please explain: _____

9. Do you have any communicable diseases that may affect your ability to perform clinical or professional duties? ☐Yes ☐No

If yes, please explain: _____

I, (print full name) _____, can attest that I am in good health and have no physical, cognitive, or mental health conditions that may affect my ability to perform my clinical or professional duties. I also attest that I have no current substance use disorder. I understand that I may not hold Carolina Family Health Centers, Inc., responsible for any physical, cognitive, or mental health conditions or addictions that I have or have not disclosed.

I verify that I have received (or declined) the Hepatitis B vaccination series. Documentation of my vaccination or declination has been provided to the HR Department.

Employee's Signature: _____ Date: _____

Reviewed by:

☐ Based on the employee's attestation, no further medical evaluation is recommended.

☐ Based on the employee's attestation, it is recommended that he/she obtain medical clearance certifying that they are fit to provide services.

Director of Human Resources' Signature: _____ Date: _____