Medical Status Long Form for *Non Work*-Related Medical Conditions
Fax completed form and requested documents to 866-280-8574 fax
Questions? Please call 855-781-3058 to speak with the Off-Duty Department

Name:		Employee ID:	Date of Birth:
Address:	Good Contact Phone:	Last Day Worked:	Supervisor:
	Job Title:	Division:	Supervisor's phone:

Could you be required to drive a company vehicle? No ☐ Yes ☐ If **Yes**, DOT/CMV certificate holder? No ☐ Yes ☐

List all medications you take regularly for the injury or illness that was the basis for the medical leave of absence:	Name of Provider Signing Below: _____ Specialty: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____

I hereby authorize my physician to release any information except family medical history or genetic information that is requested only with respect to this medical condition to the BNSF Medical & Employee Health Department and/or its designees as BNSF determines is necessary to determine my ability to safety perform the functions of my job) (or any other job I am seeking as an accommodation).

Employee's Signature: _____ ***Date:*** _____

➔ **If you cannot return to work at this time, Do Not complete this form – Provide a "No work slip" to your Leave Administrator.** ➔

SECTION 2 – PHYSICIAN/TREATMENT PROVIDER (all items must be completed)

Diagnosis or description of medical condition:	ICD Codes:

Current Physical Exam Findings and Response to Treatment:

➔ **Include a COPY of the following** related to the injury or illness that was the basis for the medical leave of absence: results of any diagnostic tests, physical therapy discharge note, operative report**, most current office progress notes –** (post op note preferred with surgery), & hospital discharge summary to demonstrate fitness for duty (include only information related to the injury or illness that was the basis for medical leave; any redactions to medical documents must be made by the physician/treatment provider, not the employee)

Employee/patient is financially responsible for any cost associated with obtaining this information

Current BP (if applicable): _____ Current LVEF % (if applicable): _____ If diabetic, current Hgb A1c %: _____	Type and date of surgery: ***Attach operative report or cardiac catheter report for review If the diagnosis affects vision, include a current corrected visual acuity. Distant: OD_____ OS_____ OU_____
Current Medication's you are prescribing for the injury or illness that was the basis of the medical leave with dosage and frequency	Is the employee's alertness impaired by a medical condition or medications? Yes ☐ No ☐ If yes, explain Has the employee discussed with you his/her job duties? Yes ☐ No ☐

*** * * * * * * * * Work Status Recommendation * * * * * * * * ***

☐ **Full Duty** (***No Restrictions***) **Effective Date:** _____ ➔ DO NOT circle a restricted activity level below

☐ **Restricted Activity** ***(Complete below)*** **Effective Date:** _____

Full Duty Date: _____ if unknown: **Next Follow-up Date**: _____

Circle applicable activity level
N = No activity
O = Occasional

Walking on uneven surfaces:	N	O	Climbing (ladder, scaffold, etc.):	N	O
Stooping, bending or twisting:	N	O	Working at unprotected heights:	N	O
Operating vehicles or machinery:	N	O	Lifting up to _____ lbs.:	N	O
Other: _____				N	O

These restrictions are: ☐Temporary ☐Long-Term ➔ *Send 2 most recent office notes and medical documents related to this injury or illness only*

Treatment Provider's Signature: _____ ***Date Completed:*** _____

Please note GINA disclaimer on instructions **Rev. 04/20**