



**** IMPORTANT ~ TIME SENSITIVE ****

Return to Work Release Form (HR 140.1) (U.S. Only)

Overview:

The employee must coordinate their return-to-work date with the Company’s disability & leave administrator (currently Lincoln Financial Group) as soon as reasonably possible as to when the employee expects to return to work. The employee must also notify their Human Resources representative (e.g., HR Business Partner).

The employee should contact these parties as soon as any restrictions are known, at a minimum of five (5) calendar days in advance of returning to work, to ensure appropriate planning can take place.

The employee must return a fully completed Return to Work Release Form signed by their physician to the Company’s Human Resources Department (e.g., HR Business Partner) five (5) calendar days prior to their return. It is the employee's responsibility to obtain the completed form from their physician.

The Company’s Human Resources Department will review the completed Return to Work Release Form to determine if the employee can safely return to work with or without restrictions or accommodations. In general, the Company will accept the employee’s Return to Work Release Form as provided and endeavor to return the employee to work within the employee’s restrictions, if any, provided that in doing so the employee does not endanger the employee’s or others’ health and safety.

Employee Name: _____ **Empl. ID:** _____ **Dept:** _____

Supervisor: _____ **HR Business Partner:** _____

Employee Instructions:

1. Provide this form to your treating physician for completion and signature.
2. Include a copy of your job description and physical requirements with the form.
3. Submit the completed and signed form to your HR Business Partner at least 5 calendar days before your anticipated return to work date.
4. This advance notice ensures your workplace will be properly prepared for your return.

Physician office Instructions:

1. Please review any job related information provided by our employee.
2. Complete & sign the section below and return to our employee.

The above named individual is:

___ Able to work full duty with no restrictions effective: _____ (date).

___ Able to work with modifications effective: _____ (date):

- | | |
|---|----------------------------------|
| ___ No lifting greater than ___ pounds | ___ No driving |
| ___ No pushing greater than ___ pounds | ___ Seated work only |
| ___ No pulling greater than ___ pounds | ___ No use of the left hand/arm |
| ___ No overhead work or work above shoulder level | ___ No use of the right hand/arm |
| ___ No kneeling/squatting | ___ Restricted eye-sight |

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___ No use of the left leg

___ Limited exposure to high noise

___ No use of the right leg

___ Limit exposure to cold/heat

___ No bending/twisting/reaching

___ Can only stand/sit ___ hours per day

___ No ladder use

___ No use of respirator when required

___ No stairs use

___ Other restrictions - Please specify: _____

Next Scheduled Appointment: _____

Estimated Date of Return to Full Duty: _____

Comments: _____

Health Care Provider Name (please print): _____

Address: _____

Telephone #: _____

Type of Practice: _____

Signature of Health Care Provider: _____ Date: _____