## **Return to Work Certification** (Medical Leave)



- ASSOCIATE: COMPLETE SECTION A
- HEALTH CARE PROVIDER: COMPLETE SECTION B
- MANAGER/SUPERVISOR OR HR REPRESENTATIVE: COMPLETE SECTION C

Dear Associate:

If you are returning from medical leave due to your own serious health condition, you must provide a written release. You will not be permitted to return to work without a release. Your health care provider's completion of SECTION B, MEDICAL RELEASE will fulfill the release requirement. If you are providing an alternate release, complete Section A and submit with your documents.

[NOTE: If you are released with a medical restriction, a Job Adjustment or accommodation review may be conducted.]								
SUBMITTAL INSTRUCTIONS								
<ul> <li>Fax to Sedgwick at 859-264-4372 or email to walmartforms@sedgwicksir.com.</li> <li>Submit to Sedgwick at least 3 days prior to your return to work.</li> <li>Provide a copy to your Supervisor or HR Representative before starting to work.</li> </ul>								
SECTION A - ASSOCIATE INFORMATION								
Name (Please Print): WIN: Date Leave Began:								
Facility #:	City/State:	Expe			cted Return to Work Date:			
Preferred Method of Home Phone#:	of Contact (Optional):	□ Cell/Text#: □ Ema			il:			
Associate's Signature: Job Title: Date:								
SECTION B - HEALTH CARE PROVIDER - MEDICAL RELEASE								
I certify that the associate named above is medically able to resume work on: Date:, 20								
This associate can return to work:								
Restriction(s): Please complete section below if patient is released with restrictions. Clarify duration, frequency and activity levels.								
Activity	Frequency, Activity Level, limitations, etc.	<b>Duration</b> (*Circle P if Permanent)	Activity	Frequency, Activity Level, limitations, etc.		Duration (*Circle P if Permanent)		
Bending		to or P	Pulling				to	or P
Breathing		to or P	Reaching	□ Overh	nead	☐ Below Knee	to	or P
Climbing		to or P	Seeing				to	or P
Communicating		to or P	Standing				to	or P
Grasping		to or P	Twisting				to	or P
Hearing		to or P	Walking				to	or P
Lifting/Carrying	□ 0-9 lbs. □ 10 lbs. □ 15 l	bs. <b>2</b> 0 lbs. <b>2</b> 5 lbs.	□ 50 lbs. □ 60 l	lbs. <b>D</b> Ot	her W	T	to	or P
Other Restrictions or Details: If you need additional room, please ensure any attached pages are signed and dated.								
Accommodation(s): If returning with restriction(s), please list suggested ways the associate can be accommodated.								
Option 1								
Option 2								
Name of Health Care Provider:					Phone:			
Mailing Address:					Fax:			
Health Care Provide	er Signature:	Date:			Email:			
SECTION C – MANAGER/SUPERVISOR OR HR REPRESENTATIVE REVIEW								
Please complete this section if Section B has been completed or if a medical release has been received. Check the appropriate associate return to work status box below. Fax the completed form to 859-264-4372 or email walmartforms@sedgwicksir.com.  [NOTE: An associate can be allowed to return to work if their restriction does not conflict with an essential job function (refer to job description).  If a conflict exists, associate must stay on leave pending an Accommodation Service Center determination.]  Date returned to work w/o restrictions:  Date returned to work with Job Adjustment:  Not Returned (If not previously discussed with Sedgwick, you will receive communication regarding next steps)  Active Worker's Compensation claim								
Name:		Signature: Title		:		Date:		