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|  | **RETURN TO WORK RELEASE FORM** |

**INSTRUCTIONS**

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| **Employee:** If your leave was for your own serious health condition and you missed at least 5 consecutive scheduled work days; please fill in your name and Employee ID Number and submit this form to your Health Care Provider for completion prior to your return to work. Then return to: [HR, Shared Services](mailto:HRServices@uchospitals.edu?subject=Attn:%20Jonathan%20Kemler%20-%20UCM%20Return%20To%20Work%20Release.), Attn: Jonathan Kemler Phone: 773.702.2355 Fax: 773.702.0265  **Health Care Provider:** Complete Section below, print completed & signed form, and return the form to the employee. Please limit your answers below to the serious health condition for which the employee has been on leave. |

**EMPLOYEE IDENTIFICATION**

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| --- | --- |
| **Employee Name:** Click here to enter text. | **Employee #:** Click here to enter text. |

**SUBMITTED BY (Health Care Provider)**

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| --- | --- | --- |
| **Name:** Click here to enter text. | | **Current Date:**  Click here to enter a date. |
| **Email:** Click here to enter text. | **Phone:** Click here to enter text. | |

**PLEASE SELECT *ONE* OF THE FOLLOWING:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Return Type:** Choose an item. | | **Effective Date:** Click here to enter a date. | | | |
| **Reduced Schedule:** Choose an item. | **Hours a Day:** Click here to enter text. | | **Begin Date:** Click here to enter a date. | | **End Date:** Click here to enter a date. |
| **Restrictions:** Choose an item. | **Begin Date:** Click here to enter a date. | | | **End Date:** Click here to enter a date. | |

**PLEASE INDICATE RESTRICTIONS, IF ANY, BELOW FOR:**

|  |  |
| --- | --- |
| **Standing (number of hours):** | Click here to enter text. |
| **Walking (number of hours):** | Click here to enter text. |
| **Sitting (number of hours):** | Click here to enter text. |
| **Lifting (number of pounds):** | Click here to enter text. |
| **Carrying (number of pounds):** | Click here to enter text. |
| **Use of hands (repetitive motions, pushing, pulling):** | Click here to enter text. |
| **Any other restrictions/Notes:** | Click here to enter text. |

**SIGNATURE OF HEALTH CARE PROVIDER**

|  |  |  |
| --- | --- | --- |
| **Signature:** | **Type Name:**  Click here to enter text. | **Date:** Click here to enter a date. |

[Have a question? Contact Us](mailto:HRServices@uchospitals.edu?subject=Attn:%20Jonathan%20Kemler%20-%20UCM%20Return%20To%20Work%20Release.)