Return to Work Certification (Medical Leave)

Walmart | sedgwick

- **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

- Fax to Sedgwick at **859-264-4372** or email to **walmartforms@sedgwicksir.com.**
- Submit to Sedgwick at least 3 days prior to your return to work.
- Provide a copy to your Supervisor or HR Representative before starting to work.

SECTION A - ASSOCIATE INFORMATION

Name (Please Print):	WIN:	Date Leave Began:
Facility #: City/State:		Expected Return to Work Date:

Preferred Method of Contact (Optional):
☐ Home Phone#: ☐ Cell/Text#: ☐ Email:

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: ☐ With No Restrictions ☐ With Restrictions (describe below)

Restriction(s): Please complete section below if patient is released with restrictions. **Clarify duration, frequency and activity levels.**

Activity	**Frequency, Activity Level, limitations, etc.**	**Duration** *(*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**	☐ Overhead ☐ 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 lbs. ☐ 20 lbs. ☐ 25 lbs. ☐ 50 lbs. ☐ 60 lbs. ☐ Other WT. ____				_____ 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 Provider 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: