PLAN YOUR RETURN | RETURN TO WORK CERTIFICATION

Return all documents to Sedgwick in one of three ways:
upload: mySedgwick®| email: WalmartForms@sedgwicksir.com | fax: 859-264-4372

Associate name: Vanessia Burns **Associate WIN: 226870296** **Case number: C106210204802053AA**

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. If you are returning with restrictions, the release information can assist us in determining if an accommodation can be provided. Email or fax it to Sedgwick as soon as possible before your return to work. Provide a copy to your manager/HR representative on your first day back.

SECTION A – TO BE COMPLETED BY ASSOCIATE (please print)		
Leave start date:	Expected return to work date:	
Facility number:	City/state:	
Preferred method of contact (optional) Home phone number:	Cell number:	Email:
Associate's signature:	**Job title:**	**Date:**

SECTION B (MEDICAL RELEASE) – TO BE COMPLETED BY HEALTHCARE PROVIDER		
I certify that the associate named above is medically able to resume work on: __ /__ /____ (MM/DD/YYYY)		
This associate can return to work (check one): __ With no restrictions __ With restrictions (please describe below)		
Activity	**Frequency, activity level, limitations, etc.**	**Duration** *(circle P if permanent)*
Bending		______to______or P
Breathing		______to______or P
Climbing		______to______or P
Communicating		______to______or P
Grasping		______to______or P
Hearing		______to______or P
Lifting/carrying (lbs)	(check one) __0-9 __10 __15 __20 __25 __50 __60 __Other (provide details below)	______to______or P
Pulling		______to______or P
Reaching	(check one) __ Overhead __ Below knee ___Other (provide details below)	______to______or P
Seeing		______to______or P
Standing		______to______or P
Twisting		______to______or P
Walking		______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 healthcare provider:		**Phone:**
Mailing address:		**Fax:**
Healthcare provider signature:	**Date:**	**Email:**

SECTION C – MANAGER/HUMAN RESOURCES REPRESENTATIVE INSTRUCTIONS WHEN RESTRICTIONS ARE NOTED			
If restrictions are noted on the release, return the associate with a job adjustment, if possible. See the Accommodation in Employment policy for more information on the job adjustment program. If unable to provide a job adjustment, contact Sedgwick at 855-489-1600 to discuss next steps. [NOTE: A job adjustment does not include creating a job, removing or reducing an essential function, transferring a portion of a job to another associate, light duty or temporary alternative duty.]			
Name:	Signature:	Title:	Date:

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