Return to Work Release Form

IMPORTANT — TIME SENSITIVE

A Return-to-Work form must be completed by your Health Care Provider and submitted to Human Resources. This form may be uploaded into Workday (preferred method) or sent by email to hr@saukprairiehealthcare.org. You must submit the return to work form at least two business days before you report for work.

You will not be permitted to work until Sauk Prairie Healthcare has received a return to work form.

Name:	

TO THE EMPLOYEE: If you are returning to work with restrictions, you need to communicate with Human Resources to determine if reasonable accommodation(s) can be made for you to return to work. You must contact Human Resources at (608) 643-7163 as soon as restrictions are known, but no later than a minimum of 2 business days in advance of returning to work, to ensure appropriate planning can take place.

Failure to timely submit this form may delay or prevent you from returning to return to work.

On the day you return to work, check in with your supervisor prior to reporting to active work.

TO BE COMPLETED BY MEDICAL PROFESSIONAL		
The above-named employee is:		
	Able to work full duty effective:	**(SKIP TO BOTTOM OF FORM)**
	Able to work with modifications effective:	**(COMPLETE BELOW)**

Employee work limitations or restrictions

Please address ONLY any physical and/or mental/behavioral limitations that:

- the employee has as a result of an impairment identified below AND
- relate to the performance of the duties of his or her employment position.

Examples of physical limitations: Lifting, bending, reaching, kneeling, sitting, standing, walking, pushing, pulling, use of hands or arms, exposure to heat or cold, etc. Include specific limitations such as the expected duration of each limitation or restriction, pound limits for lifting restrictions, or any other relevant information to help the employer understand your patient's limitations and what your patient needs to perform his/her job.

Examples of cognitive/mental/behavioral limitations: Concentration, memory, focus, oral or written communication, expressing thoughts, organization, multitasking, synthesizing information, exercising judgment, interacting with others, time management, flexibility with change management, etc. Include specific limitations such as the expected duration of each limitation or restriction, modifications to work place setting, and any other relevant information to help the employer understand your patient's limitations and what your patient needs to perform his/her job.

Identify limitations or restrictions, if any, on next page.

Identify each impairment causing limitations or restrictions	Identify the limitation or restrictions caused by this impairment (please be specific)
Use additional page if needed.	
If limitations are identified, provide estimated duration of restrictions and/or date of return to full duty (If applicable):	

Comments: _____

_____

Health Care Provider Name (please print): _____

Address: _____

Telephone Number: _____ **Fax Number:** _____

Field of Practice: _____

Signature of Health Care Provider: _____ **Date:** _____