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ABSENCE MANAGEMENT
A MEMBER OF THE TOKIO MARINE GROUP

Fitness-for-Duty / Return to Work Release Form

IMPORTANT — TIME SENSITIVE

This form must be completed by your Health Care Provider and submitted to the People Team at peopleops@upstart.com at least five business days prior to your return to work date.

Employee Name: ____

Manager:______________________________

TO THE EMPLOYEE: If you are returning to work with restrictions, you need to communicate with your employer and Matrix to determine if reasonable accommodation(s) can be made for you to return to work. You must contact the HR Representative identified above as soon as restrictions are known, at a minimum 5 business days in advance of returning to work, to ensure appropriate planning can take place.

Failure to submit this form may delay or prevent your ability to return to work.

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

TO BE COMPLETED BY HEALTH CARE PROVIDER

The above-named employee is:

_______ Able to work full duty effective:_____________(date). SKIP TO BOTTOM OF FORM.
_______ Able to work with modifications effective:__________________(date). 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.

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Employee Name: ______________________________ Employee ID No. __________

Identify the physical or mental impairment causing job-related limitations or restrictions ***Do not provide a diagnosis without patient consent in CA, CT, ME, and RI.***	**Identify the job-related limitations or restrictions caused by this impairment (please be specific – include pound limitations, durations, etc.)**
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 No.: ______________________________ **Fax No.:** ______________________________

Field of Practice: ______________________________

Signature of Health Care Provider:______________________________**Date:**__________

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