# Medical Release to Return to Work

Team Members on leave due to their own health condition are not permitted to return to work without documentation. Team members must submit this form, completed by their provider, via the "Return to Work" task in the **Self-Service Portal** or via fax at **773-825-8217**.

**Team Member Legal Name:** _____

**Work Duty Status: (Check One)**

- ☐ Team Member is authorized to work **full duty** effective ____/____/____
- ☐ Team Member is authorized to work **modified duty*** ____/____/____ - ____/____/____
  ***Check Applicable Restrictions and Note Weight/Frequency/Duration:**
  - ☐ Sitting: _____
  - ☐ Standing: _____
  - ☐ Walking: _____
  - ☐ Climbing: _____
  - ☐ Lift/Push/Pull/Reach: _____
  - ☐ Twist/Bend/Stoop: _____
  - ☐ Squat/Kneel/Crawl: _____
  - ☐ Other: _____
- ☐ Team Member is **not authorized to work** ____/____/____ - ____/____/____
  - ☐ Next scheduled evaluation date: ____/____/____

**Schedule Status: (Check One if Authorized to Work)**

- ☐ Team Member is authorized to **their regularly scheduled hours**
- ☐ Team Member is authorized to a **modified schedule** ____/____/____ - ____/____/____
  - ☐ _____ Hours per Day, _____ Days per Week
  - ☐ Other: _____

_____ _____

**Health Care Provider's Signature** **Date**

_____ _____

**Health Care Provider's Name** **Phone Number**

_____ _____

**Practice Name** **Fax Number**