Release to Return to Work

St. Luke's

This form must be completed by you AND your healthcare provider prior to your return to work if you have missed five or more consecutive shifts.

NOTE: In general, light duty is not provided for non-work related injuries. However, if you have a disability and believe that a reasonable accommodation may allow you to perform the essential functions of your position, please contact Human Resources for more information on the ADA process.

Employee's Name: _____ Phone Number: _____

(Please Sign Below) Date of Birth: _____

Job Title: _____ Department: _____

EMPLOYEE

In some instances there may be a question as to whether your medical condition may compromise your present ability to safely complete the essential functions of your position. In those cases, Occupational Health may request further information from your healthcare provider.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize the below healthcare provider to ***release all information and records related to the specific illness or injury*** referred to in this Return to Work Form (from the date of onset to present) as indicated below, including the following information if so designated:

- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS-related Treatment
- ☐ Mental Health (Other than Psychotherapy Notes)

The purpose of this Release is to evaluate my ability to safely perform the essential functions of my position. I understand this Authorization for Release may be revoked by me at any time by sending a written notice to the provider, but such revocation would not apply to any information already released by the provider in good faith. This Authorization for Release includes information to be generated and records yet to be created for services provided both before and after the date of my signature below, including the entire period in which this Authorization for Release is effective. Unless revoked early by me, this Authorization for Release expires one (1) year from the date of my signature below. I understand that the provider may not condition treatment, enrollment or eligibility for benefits upon the execution of this Authorization. A request for revocation or questions about disclosures may be sent to St. Luke's Occupational Health. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure at which time the information may not be protected by federal privacy rules. I understand authorizing disclosure of my medical information is voluntary. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524.

Employee Signature: _____ **Date:** _____

You will be contacted by Human Resources regarding your final clearance to return to work.
***Please* DO NOT return to work until you hear from Human Resources.**

HEALTHCARE PROVIDER

This section must be FULLY completed by the attending healthcare provider at the time of the employee's release to return to work. Incomplete forms cannot be processed and will be returned.

Describe relevant medical facts related to the condition for which the employee has taken leave (may include symptoms, diagnosis or continuing treatment).

_____

_____

_____ Work Related? Yes: ☐ No: ☐

Dates off Work: from: _____ to: _____

A. Patient can return to normal duty (with no restrictions) on: _____

B. Patient can return to work on _____ with the following restrictions:

_____

Clinic: _____ **Phone:** _____

Healthcare Provider's Signature: _____ **Date:** _____

**** Please fax any procedure notes or imaging reports that may be related to this illness/injury to St. Luke's Occupational Health at 218-249-6828.**