Return to Work Certification (Medical Leave) Walmart :



• ASSOCIATE: COMPLETE SECTION - A

• HEALTH CARE PROVIDER: COMPLETE SECTION - B

MANAGER/SUPERVISOR OR HR REPRESENTATIVE: COMPLETE SECTION - C

Dear Associate:

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.** Your health care provider's completion of SECTION B, MEDICAL RELEASE will fulfill the release requirement. If you are providing an alternate release, complete Section A and submit with your documents.

[NOTE: If you are released with a medical restriction, a Job Adjustment or accommodation review may be conducted.]

SUBMITTAL INSTRUCTIONS						
 Fax to Sedgwick at 859-264-4372 or email to walmartforms@sedgwicksir.com. Submit to Sedgwick at least 3 days prior to your return to work. Provide a copy to your Supervisor or HR Representative before starting to work. 						
SECTION A - ASSOCIATE INFORMATION						
Name (Please Print): WIN:			WIN:	Date Leave Began:		
Facility #: City/State:				Expected Return to Work Date:		
Preferred Method of Contact (Optional): Home Phone#: Cell/Text#: Email:						
Associate's Signature: Jo			Date:			
SECTION B - HEALTH CARE PROVIDER – MEDICAL RELEASE						
I certify that the associate named above is medically able to resume work on: Date:, 20						
This associate can return to work:						
Restriction(s): Please complete section below if patient is released with restrictions. Clarify duration, frequency and activity levels.						
Activity				ncy, Activity Level, ons, etc.	Duration (*Circle P if Permanent)	
Bending		to or P	Pulling			to or P
Breathing		to or P	Reaching	Overh	nead 🛛 🗖 Below Knee	to or P
Climbing		to or P	Seeing			to or P
Communicating		to or P	Standing			to or P
Grasping		to or P	Twisting			to or P
Hearing		to or P	Walking			to or P
Lifting/Carrying 🛛 0-9 lbs. 🗖 10 lbs. 🗖 15 lb		bs. □ 20 lbs. □ 25 lbs. □ 50 lbs. □ 60 lbs. □		os. ◘ Ot	her WT	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 Health Care Provider:				Phone:		
Mailing Address:				Fax:		
			Date:	Email:		
SECTION C – MANAGER/SUPERVISOR OR HR REPRESENTATIVE REVIEW						
Please complete this section if Section B has been completed or if a medical release has been received. Check the appropriate associate return to work status box below. Fax the completed form to 859-264-4372 or email walmartforms@sedgwicksir.com. [NOTE: An associate can be allowed to return to work if their restriction does not conflict with an essential job function (refer to job description). If a conflict exists, associate must stay on leave pending an Accommodation Service Center determination.] Date returned to work w/o restrictions: Date returned to work with Job Adjustment: Not Returned (If not previously discussed with Sedgwick, you will receive communication regarding next steps) Active Worker's Compensation claim						
Name [.]		Signature	Title			Date [.]