Release to Return to Work Form

Sedgwick Claims Management Services, Inc.
P.O. Box 14495, Lexington, KY 40512
Phone 1-855-732-8217 • Fax 1-866-856-4862

If your medical leave is longer than 10 consecutive workdays (or as the circumstances merits), once a return to work date is established, this form must be completed and provided prior to you returning to work.

Action Required!
You are responsible to have this form completed by your Health Care Provider and submitted to Sedgwick at least two days prior to your return to work.

This section is to be completed by the EMPLOYEE		
Employee Name:	**Claim Number:**	**Employee ID:**
Date Leave Began: ___/___/___	Return to Work Date: ___/___/___	
I understand I cannot return to work without a release from my health care provider.		
Employee's Signature:	**Date:** ___/___/___	

This section is to be completed by the HEALTH CARE PROVIDER	
After reviewing the job requirements with your patient, please respond to the following statements by checking the correct response, including any restrictions and recommended accommodations, if applicable. Please answer the questions with the full understanding that your patient will be required to perform **ALL** the essential functions safely and efficiently with or without reasonable accommodations as described.	
I have examined the employee named above and certify that this person is **medically able to resume working at Pacific Gas and Electric Company on**: ___/___/___	
This employee can return work:	☐ With No Restrictions ☐ With Restrictions (outline details below)
If the employee is unable to resume performing the full functions of his/her position, please state in detail the employee's restriction(s) and what accommodation(s) would allow him/her to perform the essential functions here:	
Restrictions/Accommodations are: ☐ Permanent ☐ Temporary If temporary, modified duty will last: ___/___/___ to ___/___/___ Date employee may resume full duty: ___/___/___	
Signature of Health Care Provider:	**Date:** ___/___/___
Name of Health Care Provider (Please Print):	
Address of Health Care Provider:	
Phone Number of Health Care Provider:	

To request a copy of your Job Function Analysis (JFA) to accompany this form, please contact the Stay at Work/Return to Work (SAW/RTW) team at 925-459-7270.

Action Required by Supervisor: Please fax a copy to Sedgwick at 1-866-856-4862 if you receive this form from your employee. If you need assistance with returning your employee to work with accommodations, please contact the Stay at Work/Return to Work Team at 925-459-7270 or Accommodations-Req@pge.com.