RELEASE TO RETURN TO WORK FORM INSTRUCTIONS

Purpose of the Form:
The Release to Return to Work Form must be completed when an associate is released to return to work following an absence as a result of an injury or illness.

Who Completes the Form:
The associate should complete the top portion of the form, and then give the form to his/her treating health care provider for completion.

Where Should the Form be Sent:
The completed form should be returned to the manager of the associate's work location. **The Return to Work form must be completed before the associate can return to work.**

You must also contact MetLife and report your Return to Work date at 1-888-343-6886. This information must be received by MetLife in order to manage your claim.

Contact Information:
For questions about the Release to Return to Work Form, please contact your local Human Resource Department. For questions regarding your leave request, please contact MetLife at 1-888-343-6886.

Please contact your manager and/or your Human Resource Department regarding your return to work plan.

RELEASE TO RETURN TO WORK FORM

To be completed and submitted only when an associate is released to return to work following an absence as a result of an injury or illness. The associate should complete Section I of the form. The associate's treating health care provider should complete Section II of the form.

The associate must discuss his/her return to work plan with his/her manager and/or Human Resource Department prior to the return to work date.

SECTION I: To be completed by the associate

EMPLOYEE (LAST, FIRST, M.I.)	EUID	DOB (MM,DD,YYYY)	PHONE NUMBER
HOME ADDRESS			
DIVISION NAME	SUPERVISOR/MANAGER OR HR MANAGER NAME		

SECTION II: To be completed by the associate's treating health care provider

The patient noted above is released to return to work on: _____

☐ With no restrictions

☐ With the following restrictions **Please include any restrictions of any kind and any details related to any restrictions** *(i.e. no lifting more than 5lbs for 2 weeks, etc.)*

_____

_____

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_____

Health Care Provider's Name	Health Care Provider's Signature	Today's Date

Health Care Provider's Address	Health Care Provider's Phone Number