



### RETURN TO WORK RELEASE

This Return to Work Release must be completed by your Healthcare Provider.

**Submit the completed form to your HR Business Partner and LOA@aecom.com 3-5 business days before your scheduled return to work date.**

Employee Section:	
Employee Name:	Employee ID #:
Employee Email:	Employee Phone #:
Supervisor Name:	HR Business Partner (HRBP) Name:
Leave Start Date:	Leave End Date:
<b>I understand that I cannot return to work without a release from my health care provider. Also if my release includes restrictions I must contact my HR Business Partner to begin review process PRIOR TO RETURNING TO WORK.</b>	
Employee's Signature:	Date:

Health Care Provider Section	
Health Care Provider Name, Address & Phone #	
I have examined the employee named above and certify that this person is medically able to resume working as of this date. (Date: _____)	
The Employee can return to work: <input type="checkbox"/> With <u>No</u> Restrictions <input type="checkbox"/> With Restrictions	The foregoing <u>restrictions</u> are: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary Until (Date: _____)
If Employee is returning with <u>restrictions</u> , please provide detail description and duration of each applicable restriction.	
<input type="checkbox"/> Walking	
<input type="checkbox"/> Sitting for extended period of time	
<input type="checkbox"/> Lifting (Enter lbs _____)	
<input type="checkbox"/> Working for a continuous day <small>(aside from legally required lunch and/or rest breaks)</small>	
<input type="checkbox"/> Other	
Signature of Health Care Provider:	Date:
Print Name and Title of Health Care Provider completing form:	

***If you are unable to return to work please contact your HRBP before your return to work date.***