RETURN TO WORK RELEASE

This Return to Work Release must be completed by your Healthcare Provider.
Submit completed form to your HR Business Partner and **LOA@aecom.com** before you return to work.

Employee Section

Employee Name:	Employee ID #:
Employee Email:	Employee Phone #:
Supervisor Name:	HR Business Partner (HRBP) Name:
Leave Start Date:	Leave End Date:

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 the review process PRIOR TO RETURNING TO WORK.

Employee's Signature:	Date:

Health Care Provider Section

Heath 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: _____)

This Employee can return to work: ☐ With No Restrictions ☐ With Restrictions	The foregoing restrictions are: ☐ Permanent ☐ Temporary Until (Date: _____)

If Employee is returning with restrictions, please provide detail description and duration of each applicable restriction.

☐ Walking	
☐ Sitting for extended period of time	
☐ Lifting (Enter lbs_____)	
☐ Working for a continuous day (aside from legally required lunch and/or rest breaks)	
☐ 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 prior to your return to work date.