

Return to Full Duty Work Form

THIS DOCUMENT MUST BE COMPLETED IN FULL BY THE PARTIES BELOW

*Leave Returning From: *(This form is for employees on leave from their normal schedule/job duties for 90+ days)*

- OJI
 Military
 FMLA
 STD
 LTD
 Sick
 Other

Employee Name: _____ Department: _____

Employee ID Number: _____ Employee Supervisor: _____

Date of Notification to Occupational Health Nurse/HR: _____ Projected Date of Return to Work: _____

1 – Employee

Employee, Signature

Date

- I acknowledge, understand and agree to the following:
- This form must be completed prior to my return to my normal shift/job duties
 - It is my responsibility to go to each department for assignments/signatures
 - If I have items that cannot be completed on the day I receive this form I will see the On-Duty supervisor immediately for a temporary job assignment. This will occur each day until all of the items required are complete.
 - I will clock in under my department (i.e. / Opr, MedSvs, etc.) and I will clock out for lunch, training, and in- service – then clock back in under my department until the end of my shift.
 - While in transition, I am still held to the standards and policies to include attendance.

ACTION ITEMS – PLEASE DO NOT SIGN OFF ON YOUR AREA UNTIL THE EMPLOYEE HAS COMPLETED ALL REQUIREMENTS FOR YOUR AREA

1 – Occupational Health Nurse/HR

OHN/HR, Signature

Date

- Date Notified about Return to Work: _____
- Date Leave Report Updated and Sent (clearly stating employee status): _____
- Appropriate paperwork and release orders from physician received if applicable

2 – Operations Supervisor/Manager

Operations Sup/Mgr Signature

Date

- Please assign the employee to a temporary position until their full release (if available)
- Department/Job Employee assigned to _____

3 – Medical: Please see Occupational Nurse

OHN Signature

Date

- Flu Shot or Declination, if applicable
- MEDPAT
 - Date Scheduled: _____ Date Completed: _____
- Complete Respirator Questionnaire if required prior to Fit Test Date of Concentra Visit (if applicable) _____
- Fit Test
 - Date Scheduled: _____ Date Completed: _____

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4 – Education: Please see Med Services

Clinical Education, Signature

Date

All relevant In-Service Maintenance
Date Scheduled: _____ Date Completed: _____

Required Certifications/Credentials
Date Scheduled: _____ Date Completed: _____

FTO/Crew Chief assignment for evaluation & ride time
Date Scheduled: _____ Date Completed: _____

Notified Scheduling about ride time

Notify Human Resources of training fulfillments *(Can only be signed by Clinical Education Supervisor or approved designee and must be done before COB of date completed)*
Clinical Education Signature: _____ Date Completed: _____

5 – Scope of Practice: Please see Clinical Improvement

Clinical Improvement, Signature

Date

Required Testing and Oral Boards
Date Scheduled: _____ Date Completed: _____

Required Testing and Oral Boards
Date Scheduled: _____ Date Completed: _____

6 – Risk & Safety: Please see Risk and Safety

Risk and Safety, Signature

Date

Driver's license check

Driver Training, if needed

OSHA Training, Corporate Compliance

Date Scheduled: _____ Date Completed: _____

7 – Occupational Health Nurse/HR

Occupational Health Nurse/HR, Signature

Date

Notified Scheduling, OA, Ops Managers, Ops Supervisors, OHN, and R&S of employee status

Scheduling notified to return the employee to their normal schedule/job duties via Leave Report:

Date