Medical Verification & Return to Work Form:
For Employee Illness or Injury

Section 1: Completed by Employee

Patient's Authorization to Release Information: *I hereby authorize my healthcare provider to complete this form in its entirety. Additionally, I request that my healthcare provider forward the completed form directly to my employer.*

Print Name: _____ **Job Title:** _____

Signature: _____ **Date:** _____

Section 2: Completed by Healthcare Provider

Date of Exam: _____ **Date of Next Exam:** _____

1. Describe your patient's medical condition ☐ Check here if this is a Worker's Comp Injury

_____

_____

2. **In detail, outline the employee's restrictions** (ex: lifting, crouching, sitting, standing capabilities, etc.)

_____

_____

_____

a. What is the projected duration of these restrictions? _____

b. Is the patient released to work on light duty if the employer can accommodate these restrictions?

☐ Yes ☐ No

3. If your patient IS released to return to work:

a. What date is the patient released to return to work within the restrictions above? _____

b. Number of hours the patient is capable of working: _____hrs/day _____days/week

c. If known, indicate the date the patient can return to work *without* restrictions: _____

4. If your patient is NOT released to return to work:

a. I understand that ALLETE and its subsidiaries provide sedentary and reduced work schedules to any employee unable to perform their regularly assigned job responsibilities due to illness or injury.

☐ Yes ☐ No

b. Please describe in detail the restrictions preventing a return to work in ANY light duty / sedentary work capacity for ANY length of time.

_____

_____

_____

_____ _____

Health Care Provider Printed Name Clinic or Practice Name

_____ _____ _____

Health Care Provider Signature Phone Number Date

Return Completed Form to:

ALLETE (Attn: HR – Absence Mgmt.)

Confidential Fax: 218-355-3914 (primary) | 218-355-3801 (secondary)

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