



# PLAN YOUR RETURN | RETURN TO WORK CERTIFICATION

Return all documents to Sedgwick in one of three ways:

upload: mySedgwick® | email: WalmartForms@sedgwick.com | fax: 859-264-4372 or 859-280-3270

Associate name: David Whitehouse Associate WIN: 213412397

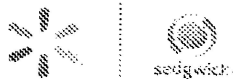
Case number: 4A2308GP6YC0001G1

If you are returning from medical leave due to your own serious health condition, you must provide a written release. You will not be permitted to return to work without a release. If you are returning with restrictions, the release information can assist us in determining if an accommodation can be provided. Email or fax it to Sedgwick as soon as possible before your return to work. Provide a copy to your manager/HR representative on your first day back.

<b>SECTION A – TO BE COMPLETED BY ASSOCIATE (please print)</b>	
Leave start date: 08/10/2023	Expected return to work date: 10/14/2023
Facility number: 613	City/state: ORMOND BEACH, FL
Preferred method of contact (optional)	
Home phone number: 386-677-3888 Cell number: 386-871-2857 Email: david@tntsouth.com	
Associate's signature: <i>David Whitehouse</i>	Job title: APPARELTA Date: 10/09/2023

<b>SECTION B (MEDICAL RELEASE) – TO BE COMPLETED BY HEALTHCARE PROVIDER</b>		
I certify that the associate named above is medically able to resume work on: 10/14/2023 (MM/DD/YYYY)		
This associate can return to work (check one): <input type="checkbox"/> With no restrictions <input type="checkbox"/> With restrictions (please describe below)		
Activity	Frequency, activity level, limitations, etc.	Duration (circle P if permanent)
Bending		to or P
Breathing		to or P
Climbing		to or P
Communicating		to or P
Grasping		to or P
Hearing		to or P
Lifting/carrying (lbs)	(check one) 0-9 10 15 20 25 50 60 Other (provide details below)	to or P
Pulling		to or P
Reaching	(check one) Overhead Below knee Other (provide details below)	to or P
Seeing		to or P
Standing		to or P
Twisting		to or P
Walking		to or P
Other restrictions or details: If you need additional room, please ensure any attached pages are signed and dated.		
Accommodation(s): If returning with restriction(s), please list suggested ways the associate can be accommodated.		
Option 1		
Option 2		
Any and all charges for completion of forms and copy of records are the responsibility of the patient.		
Name of healthcare provider: CONVIVA Physician Group	Phone: 386-506-0111	
Mailing address: 420 S. MOVA RD, Suite 5, ORMOND BEACH, FL 32174	Fax: 1-844-899-3686	
Healthcare provider signature: <i>[Signature]</i>	Date: 10/9/23	Email:

<b>SECTION C – MANAGER/HUMAN RESOURCES REPRESENTATIVE INSTRUCTIONS WHEN RESTRICTIONS ARE NOTED</b>			
If restrictions are noted on the release, return the associate with a job adjustment, if possible. See the Accommodation in Employment policy for more information on the job adjustment program. If unable to provide a job adjustment, contact Sedgwick at 855-489-1600 to discuss next steps. [NOTE: A job adjustment does not include creating a job, removing or reducing an essential function, transferring a portion of a job to another associate, light duty or temporary alternative duty.]			
Name: <i>Travis White</i>	Signature: <i>[Signature]</i>	Title: <i>MD</i>	Date: 10/9/23



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9/5/2023

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