Send completed form to:
AbSolve Leave Administration
P.O. Box 1328 Mount Laurel, NJ 08054
Phone: 1-800-401-2691
Fax: 1-800-728-7028

STANDARD SECURITY LIFE INSURANCE COMPANY

RETURN TO WORK FORM

Employee Name: _____ Case #: _____

Date Leave Began: _____ Date of Birth: _____

☐ The employee is able to return to regular, full duty on ___/___/_____
☐ The employee can return to work with restrictions stated below. The restrictions are for the period of ___/___/_____ through ___/___/_____
☐ These restrictions are ☐ temporary ☐ permanent
☐ The employee is able to return to work on a reduced schedule for ____ hours per day from ___/___/_____ through ___/___/_____
☐ The employee is unable to return to work until ___/___/_____

Please complete only if the employee has restrictions:

In a ____ hour workday, employee can (circle full hour capacity for each activity):

Sit	1	2	3	4	5	6	7	8	9	10	11	12
Stand	1	2	3	4	5	6	7	8	9	10	11	12
Walk	1	2	3	4	5	6	7	8	9	10	11	12

Are there restrictions in:	Yes	No	Comments
Lifting/Carrying: _____lbs	☐	☐	_____
Bending	☐	☐	_____
Squatting / Kneeling	☐	☐	_____
Crawling	☐	☐	_____
Climbing (specify)	☐	☐	_____
Driving	☐	☐	_____
Working at heights / unprotected heights	☐	☐	_____
Uneven ground	☐	☐	_____
Reaching overhead	☐	☐	_____
Pushing / Pulling: _____lbs	☐	☐	_____

I examined _____ on ___/___/___ and certify that the employee
☐ is able to return to full, regular duty work or ☐ is **not** able to return to full, regular duty work

_____ _____
Healthcare Provider Signature Date

Healthcare Provider Name: _____
Certificate License No. and State: _____
Address: _____
City, State, Zip: _____
Phone Number: _____

I understand the instructions above. I will allow the release of the above information to my employer.

_____ _____
Employee Signature Date