Directions/Medical

Stellantis Reinstatement from Disability Leave Information

Stellantis employees are required to submit both pages of this form prior to returning to work. Non-standard forms or doctor notes will not be accepted.

This substantiation requirement is separate from anything submitted for the employee's disability claim while on leave. The following form is required as the medical statement/release to return to work and must be completed by the employee's health care provider.

Employees, make sure your healthcare provider has filled out the form in its entirety; missing information could delay your return to work and could cause Attendance Disciplines to be issued.

Falsifying or altering information on this form could lead to disciplinary action up to and including termination

NOTE: The release **MUST** be signed by the treating, legally licensed health or mental care provider which includes:

- Physician
- Nurse Practitioner
- Physician's Assistant
- Social Worker
- Counselor

Nursing licensure is **NOT ACCEPTABLE** i.e., RN, MA, LPN, LVN etc.

**Do not complete Medical Diagnostic Codes for individuals in CA, CT, ME, or RI.*

IMPORTANT CAREFULLY REVIEW THE FOLLOWING: The **Genetic Information Nondiscrimination** Act of 2008 (GINA) prohibits employers and other entities covered by GINA, Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. **To comply with this law, we are asking that you and your medical provider(s) not provide genetic* information in responding to this form.**

**Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.*

Date (date form is completed): _____ (MM/DD/YY) Employee ID (CID): _____

Employee Name: _____

Information for Medical Department Only - **Do not answer for individuals in CA, CT, ME, or RI.*

Patient's Diagnostic Code(s) _____ _____ _____ _____ _____

Comments: _____

_____

_____

Restriction Data

Date (date form is completed): _____ (MM/DD/YY) Employee ID (CID): _____

Employee Name: _____

Date of First Appointment for Injury or Illness: _____ (MM/ DD / YY)

Employee was unable to work from: _____ (MM/ DD / YY) through _____ (MM/ DD / YY)

List All Dates of Treatments for this Illness or Injury _____

_____

Please select one return to work option below: ***(Return to work date cannot be the same as the last date employee was unable to work)***

☐ Employee can return to work with no restrictions on: _____ (MM/ DD / YY)

☐ Return to work with restrictions on: _____ (MM/DD/YY) through _____ (MM/ DD / YY)

Note: Complete this section if the employee is being medically released to return to work with restrictions that are associated with, or result from the medical condition(s), for which the employee was on a disability leave.

Employee's Capabilities:

Lift/Carry ☐ 0 lbs ☐ 1-10 lbs ☐ 11-25 lbs ☐ 25-50 lbs ☐ Over 50 lbs

	Not At All	Up To 3 Hrs	Up To 5 Hrs	Up To 8 Hrs	Up To 12 Hrs
Bend _____ degree.	☐	☐	☐	☐	☐
Squat/Kneel.	☐	☐	☐	☐	☐
Twist/Turn.	☐	☐	☐	☐	☐
Walk/Stand.	☐	☐	☐	☐	☐
Reach Above Shoulders.	☐	☐	☐	☐	☐
Reach Below Knees.	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Climb.	☐	☐	☐	☐	☐
Rotate Activities/Positions	☐	☐	☐	☐	☐
Use Feet to Operate Controls. . .	☐	☐	☐	☐	☐
Exposure to dust/fumes/gases .	☐	☐	☐	☐	☐

	Yes	No
Is the employee taking medicine that can impair his/her ability to safely perform job duties?	☐	☐
Respirator use?	☐	☐

Restrictions

Overtime is allowed (per day):
☐ No Restrictions ☐ 0 hrs ☐ 2 hrs ☐ 4 hrs ☐ 6 hrs

Restriction	Left	Right	Both
No vibrating tools.	☐	☐	☐
No coarse manipulations.	☐	☐	☐
No gripping/grasping.	☐	☐	☐
No heavy grasping.	☐	☐	☐
One handed work only.	☐	☐	☐
Hand/Wrist restrictions.	☐	☐	☐
No outstretched arms	☐	☐	☐
No driving motor vehicles. . . .	☐	☐	☐
Sight impaired.	☐	☐	☐
Hearing impaired.	☐	☐	☐

	Yes	No
Can employee operate forklift/machinery.	☐	☐

OTHER: _____

I hereby certify that the facts in this document are true and correct.

_____
Licensed Medical Practitioner Signature Licensed Medical Practitioner Phone #

_____
Licensed Medical Practitioner Print Name Practice Name

_____ _____ _____
Practice Street Address State Zip Code

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