Stellantis Medical Reinstatement Form

Directions/Medical Data – PAGE 1

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. **NOTICE: Return to work date cannot be the same as the last date you were unable to work - make sure your Provider does not make these dates the same!**

Falsifying or altering information on this form could lead to disciplinary action up to and including termination
Forms with Whiteout or Mark Outs or any other manual alterations will not be accepted

NOTE: The release **MUST** be signed by the treating, legally licensed health or mental care provider which includes (but not limited to):

Physician	**Certified Nurse Midwife**
Nurse Practitioner	**Social Worker**
Physician's Assistant	**Counselor**

**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.*

Information to be completed by Patient's Medical Practitioner

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

Patient Name: _____

This information will only be seen/used by Stellantis Medical Dept. **Do not answer for individuals in CA, CT, ME, or RI.*

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

Comments: _____

_____

_____

_____

_____

Stellantis Medical Reinstatement Form

Restrictions Data – PAGE 2

Information to be completed by Patient's Medical Practitioner

Patient Name: _____ Stellantis Employee ID (CID): _____

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

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

(Return to work date cannot be the same as the last date employee was unable to work)

List All Dates of Treatments for this Illness or Injury _____

ONLY 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

OR

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

NOTE: ONLY 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 conditions(s) for which the was on a disability leave.

	Percent of Work Shift								Percent of Work Shift			
	None	1-33%	34-66%	67-100%					None	1-33%	34-66%	67-100%
Restriction						**Restriction**	**R**	**L**				
Neck Flexion						Hand Grip/Grasp						
Neck Extension						Hand Wide Grip/Grasp						
Neck Rotation						Hand Pinch Grip/Grasp						
Back Bending/Twisting						Wrist Twist						
Standing						Elbow Twist						
Sit/Stand Option						Shoulder – Reach ABOVE						
Walking						Shoulder – Reach						
Climbing						Lifting _____Lbs.						
Metalworking Fluid Exposure						Push/Pull _____ Lbs.						
Use of Cane/Crutches						Leg-Stoop/Squat						
Shade Tint 2 Glasses						Leg – Elevated						
Dust/Smoke Exposure												
Fume Exposure						Arm – NO USE						
Solvent Exposure						Hand – NO USE						
Oil/Grease Exposure						Must Wear Brace/Splint						
Forklift Driving												
Powered Industrial Vehicle Driving						OTHER:						
Operating Moving Machinery												
Working on Platforms												
Work Beyond Hours of Regular Shift												

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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