



Banner Health®

**Return to Work Program Employee Request**

Employee Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Lawson #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Message Phone #: \_\_\_\_\_  
Home Address: \_\_\_\_\_

Current Department: \_\_\_\_\_ Current Supervisor: \_\_\_\_\_  
Job Title: \_\_\_\_\_ Shift: \_\_\_\_\_ # of hours worked per week: \_\_\_\_\_

Date released to Light Duty: \_\_\_\_\_  
Reason referred to Light Duty Work: **(Please check one)**  
 Short Term Disability (STD)  
 Workers' Compensation (WC)

**Please attach your Occupational/Employee Health Treatment and Status Report or Return to Work form.**

Times available to work: **(Please specify)** \_\_\_\_\_  
Current Employment Status: **(Please check one)**  
 Full-Time (FA)  
 Part-Time (PA)

**Technical/Interpersonal skills; i.e. typing, computer skills (software), office or medical equipment, public speaking, etc.**

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return this form to your local RTW coordinator.**

**For RTW Coordinator Use Only:**  
Current Employment Status: \_\_\_\_\_ Current FTE: \_\_\_\_\_ Shift: \_\_\_\_\_  
Confirm Date released to Light Duty: \_\_\_\_/\_\_\_\_/\_\_\_\_ Claim # \_\_\_\_\_  WC  STD  
Claim Specialist: \_\_\_\_\_  
Occupational Health/Employee Health Treatment and Status Report received:  Yes  No  
Restrictions: \_\_\_\_\_  
Placed:  Yes  No If no, reason: \_\_\_\_\_  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Department: \_\_\_\_\_  
Facility: \_\_\_\_\_  
Supervisor: \_\_\_\_\_ Phone Number: \_\_\_\_\_