Medical Verification & Return to Work Form:
For Employee Illness or Injury

Section 1: Completed by Employee

Patient's Authorization to Release Information: *I hereby authorize my healthcare provider to complete this form in its entirety. Additionally, I request that my healthcare provider forward the completed form directly to my employer.*

Print Name: _____ **Job Title:** _____

Signature: _____ **Date:** _____

Section 2: Completed by Healthcare Provider

Please describe your patient's medical condition.

_____

_____

Date of Exam: _____ **Date of Next Exam:** _____

1. **For your patient who is NOT released to return to work:**
   a. I understand that ALLETE and its subsidiaries provide sedentary and reduced work schedules to any employee unable to perform their regularly assigned job responsibilities due to illness or injury.
      ☐ Yes ☐ No

   b. Please describe in detail the restrictions preventing a return to work in ANY light duty / sedentary work capacity for ANY length of time.
      _____
      _____

   c. What is the projected duration of these restrictions? _____

2. **For your patient who IS released to return to work:**
   a. As of what date is the patient released to return to work? _____
   b. Denote the number of hours the patient is capable of working. _____/day _____/week
   c. Does the patient have any work restrictions?
      ☐ Yes ☐ No
   d. If "*Yes*," please provide a detailed description of any restrictions:
      _____
      _____

   e. Please indicate the date the patient can return to work without restrictions: _____

_____ _____
Health Care Provider Printed Name Clinic or Practice Name

_____ _____ _____
Health Care Provider Signature Phone Number Date

Return Completed Form to:

ALLETE (Attn: HR – Absence Mgmt.)
Confidential Fax: 218-355-3914 (primary) | 218-355-3801 (secondary)
30 W. Superior St. Duluth, MN | 55802-2093

Medical Verification & Return to Work Form:
For Spousal / Dependent Illness or Injury

Section 1: Completed by Employee and Patient

Employee Name: _____ **Employee Number:** _____

Job Title: _____ **Date:** _____

Patient's Authorization to Release Information: *I hereby authorize my / my minor child's healthcare provider to complete this form in its entirety. Additionally, I request that the provider forward the completed form directly to ALLETE.*

Patient Name: _____ **Date:** _____

Patient / Authorized Representative Signature: _____

Section 2: Completed by Healthcare Provider

Please describe your patient's medical condition.

_____

_____

Date of Exam: _____ **Date of Next Exam:** _____

1. Given the patient's condition, is the above-named employee's presence to provide care medically necessary?
   ☐ Yes ☐ No

2. If "Yes,"…
   a. Please describe, in detail, any restrictions which require medical care to be provided.
      _____
      _____

   b. What is the projected duration of the restrictions requiring medical care?

      _____ Hours / Day _____ Days / Week

      _____ Start Date _____ End Date

_____ **Health Care Provider Printed Name**

_____ **Clinic or Practice Name**

_____ **Health Care Provider Signature**

_____ **Phone Number**

_____ **Date**

Return Completed Form to:

ALLETE (Attn: HR – Absence Mgmt.)
Confidential Fax: 218-355-3914 (primary) | 218-355-3801 (secondary)
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