Clorox

AUTHORIZATION TO RETURN TO WORK

The Clorox Company

First Name:	Last Name:
First Day Missed:	Claim Number:

COMPLETE THE FOLLOWING STEPS:
STEP 1: Complete all of the above information above.
STEP 2: Give this document to your Health Care Provider and instruct him/her to complete.
After your Health Care Provider has completed and signed this form:

- **Please provide completed form to your local HR, or**
- **Email to leave.of.absence@clorox.com.**

Only one copy of this form, so please choose one method of delivery only.
You may not be allowed to return to work until this completed form has been received.

INSTRUCTIONS TO HEALTH CARE PROVIDER: *Complete and return to your patient directly as instructed above.*

Prescription Medication:
Is the employee taking any prescription medication that may impair his/her mental or physical abilities to perform potentially hazardous activities such as operating high-speed machinery or driving a fork truck? (*please only include prescriptions related to this particular health condition)*

❑ Yes ❑ No

Please check one of the following:

❑ The patient is released to work without restrictions.
The patient is fully released to work as of the following date: _____

❑ The patient is released to work with the following restrictions and/or limitations.
From _____ (date) through _____ (date)
Please describe in detail restrictions and/or limitations below:

_____

_____

_____

_____

_____

The Genetic Information Non-Discrimination 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 not provide any genetic information when responding to this request for medical information. 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's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

This individual is currently under our professional care.

Name of Health Care Provider: _____ Date: _____

Address of Health Care Provider: _____

Office Phone: _____ Office Fax: _____

Signature of Health Care Provider: _____