Union Pacific Railroad

Return- to-Work Medical Status Form (Form 1600)

To be completed and returned as soon as your treating healthcare provider has released you to return to work after being off work due to a personal medical leave of absence 4 days or more. **Please fax this completed form to (402) 233-2081 or send via email to medicalrtw@up.com**

Medical-related absences greater than 30 days or for reportable health conditions will typically require submission of records in addition to this form. HMS Clinical Services will contact you after receipt and review of your submitted form to advise of next steps. Please contact Clinical Services at (402) 544-7011 with any questions.

To be Completed by the Employee (Fill in blank fields):

Employee Name:		Employee ID:		Job Title :	
Employee Phone:		Employee Email:		Last Day Worked:	

Instructons for Healthcare Providers

This individual is a Union Pacific Railroad employee whose job duties involve safety critical activities that may affect the safety of the employee,_co-workers, the public, and the environment. To help ensure workplace and transportation safety, Union Pacific requires all employees in safety_critical positions submit information prior to returning to work after a medically-related absence. As part of Union Pacific's review, employees are required to provide relevant medical records to Union Pacific Health and Medical Services (HMS), so HMS may determine if the individual has a health condition or uses a medication that may pose a safety risk at work. Per UPRR policy, it is the responsibility of HMS to make the final fitness for duty determination. Employees are responsible for any cost incurred during this process, including record submission costs. We appreciate your assistance in this mater.

To be Completed by the Treating Healthcare Provider: Summary of Current Health Status

1. Please indicate if the employee was off work due any of the following reasons:

Yes	No	CONDITION CATEGORY
		Seizure, stroke/TIA, loss of consciousness episode(s) or other neurological condition(s)
		Conditions affecting eyes or vision, eye surgery, or LASIK (does not include use of glasses or contacts)
		Conditions affecting the heart/valves/blood vessels, heart surgery or procedure, or heart arrhythmias
		Conditions affecting hearing
		Diabetes treated with insulin
		Sleep apnea, hypersomnia, narcolepsy, or other sleep disorders
		Mental health condition(s) requiring hospitalization; any substance use disorder(s); suicidal or homicidal ideation; or psychosis
		Any hospitalization for 1 or more days, or surgery requiring more than local anesthesia

2. Due to this current condition/episode of care, what date range was the patient unable to work? Start Date _____ to End Date _____ (Month/Date/Year)

3. Diagnoses related to this leave of absence:

_____

4. Current pertinent physical examination findings:

_____

5. Pertinent clinical diagnostic testing performed and results (ex: lab work, MRI, etc):

_____

6. Treatments (ex: physical therapy, hospitalizations, procedures or surgeries with dates performed):

_____

_____

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Employee Name		Employee ID:		Job Title :	

7. List of all current medications with dosages/frequencies:

_____

_____

8. Will any medication the employee is taking adversely affect alertness, coordination, judgement, or gait?___YES ___NO
If YES, please explain: _____

9. Has the employee discussed their job duties and the safety sensitive nature of their work with you?___YES ___ NO

10. Return to Work Recommendation:

___Full Duty with No Restrictions; Effective Date: _____

___Currently Unable to Return to Work with Anticipated Return Date: _____

___Restricted Activity at Work; Limitations as indicated below:

Current Level of Functional Abilities: (Please address only those abilities related to this injury/illness).

	Rare/Occasional/Freq				Rare/ Occasional/ Freq		
☐ LIFT UP TO____LBS	☐	☐	☐	☐ LIMIT BENDING/TWISTING	☐	☐	☐
☐ OVERHEAD LIFT UP TO____LBS	☐	☐	☐	☐ LIMIT KNEELING/SQUATTING	☐	☐	☐
☐ CARRY LIFT UP TO____LBS	☐	☐	☐	☐ LIMIT WALKING/STANDING(UNEVEN SURFACE)	☐	☐	☐
☐ NO CLIMBING _____ (i.e. Ladders, Stairs, Railcards)				☐ LIMIT USE OF ☐ RIGHT ☐ LEFT HAND	☐	☐	☐
☐ NO DRIVING ☐ PERSONAL VEHICLES				☐ LIMIT USE OF ☐ RIGHT ☐ LEFT FOOT	☐	☐	☐
☐ COMPANY VEHICLES				☐ LIMIT SITTING	☐	☐	☐

☐ NO OPERATION OF MOVING EQUIPMENT

☐ COGNITIVE LIMITATION:_____

☐ ENVIRONMENTAL LIMITATION:_____

☐ OTHER LIMITATION: _____

These restrictions are: ☐ Permanent ☐ Temporary

If temporary, please indicate end date: _____

11. Date of next visit: _____

Provider Signature _____ Date _____

Print Provider Name _____ Specialty _____

Phone Number _____ Fax _____

Street Address _____ City, State, Zip _____

This information is confidential and maintained by Union Pacific Health & Medical Services.
(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 asspecifically 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 or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services

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