American Airlines

## Return to Work Form - Overhaul Support Mechanic

| First Name | Last Name | AA Employee # | Base |
|---|---|---|---|
| | | | |

| Email Address | Phone Number |
|---|---|
| | |

**To the Health Care Provider,**
We would like to thank you for your care and treatment of our colleague and ask that you partner with us by completing the information below in order for us to process our employee's request to return to work.

This employee has job functions at our company that could affect the employee's safety, that of their co-workers or the public. The safety of our employees and customers is a priority for our company, the Federal Aviation Administration (FAA), Department of Transportation (DOT) and Occupational Safety and Health Administration (OSHA).

The essential functions and required physical demands of an **Overhaul Support Mechanic** below, although not a comprehensive inventory of all essential functions and required physical demands, indicate the general nature and level of work performed by employees within this job classification. The failure to perform these functions properly may result in serious injury to passengers, employees, and ground equipment and company aircraft damage.

**Treating Health Care Provider:** In order to evaluate our employee's request to return to work, and/or safely return our employee back to work, please review each job function and physical demand listed below. If our employee has a restriction(s) applicable to any of the functions or demands listed, please explain the restriction(s) on page 2 of this form.

- Ability to walk, sit and stand for prolonged periods of time
- Ability to work at heights in excess of 80 feet off the ground while wearing safety harness
- Work in a high noise environment
- Routinely engage in tasks related to bending, stooping, crawling, reaching and placing
- Routinely engage in pushing, pulling and lifting up to 67lbs
- Operate a variety of tools and equipment in the process of assembling, disassembling, repairing and installing aircraft components
- Ability to distinguish all colors
- Read and interpret printed or computerized maintenance manuals
- Possess cognitive skills to process paperwork, perform simple mathematical functions, and identify discrepancies
- Handle approved dangerous goods
- Operate and drive machinery in confined and limited space areas including docks, jetbridges, trucks, tugs and aircraft which requires depth perception
- Ability to work in areas where wearing Personal Protective Equipment (PPE) may be required
- Work well under stress in a safety and deadline driven environment
- This employee is subject to Department of Transportation (DOT) drug and alcohol testing

**I understand the essential job functions and physical demands listed above. I certify that I am the treating healthcare provider for this employee's recent absence from work.**

**I confirm my patient has been under my care since** _____ **and is able to return to work <u>WITHOUT RESTRICTIONS.</u>**
mm/dd/yyyy

**Return To Work Date<u>:</u>** _____
mm/dd/yyyy

Health Care Provider (print name): _____

Specialty/Type of Practice: _____

Phone Number: _____ Fax: _____

Health Care Provider Signature: _____ Date: _____

**Please fax the completed form to 1-855-895-3685**

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|---|---|---|---|
| _____ | _____ | _____ | _____ |

**Treating Health Care Provider (continued):**

I understand the essential job functions and physical demands listed on page one. I confirm my patient is currently able to return to work **WITH RESTRICTIONS**.

Return To Work **WITH RESTRICTIONS**: Start Date: _____ End Date: _____
mm/dd/yyyy mm/dd/yyyy

Please complete the following:

1. List the specific restrictions preventing or impacting the Employee's performance (attach additional sheets as necessary)

_____

_____

_____

_____

2. Full Duty release **WITHOUT RESTRICTIONS**: _____
mm/dd/yyyy

**By signing this form, you are certifying you are the treating Health Care Provider (HCP) for this employee's recent absence from work.**

Health Care Provider (print name): _____

Specialty/Type of Practice: _____

Phone Number: _____ Fax: _____

Health Care Provider Signature: _____ Date: _____

**GINA Compliance Notice:** 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 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.

**Employee Notes:**

1. Your return to work status should be updated on Jetnet within 2 business days.
2. Depending on your position, base and time away from work, you may be required to undergo a fingerprint/background check prior to reporting back to work. Contact your manager to review your specific requirements.
3. If returning to work with job restrictions, you will need to speak with your supervisor, and review the Americans with Disabilities Act and Modified Duty policies located on Jetnet.
4. See your station/base manager/supervisor/lost time personnel upon returning to work.

**Please fax completed form to 1-855-895-3685**