Waiver of Right to Return to Original Position

Instructions: This form will be completed in the event an employee returns to work in an alternate position prior to the end of one year after the start of leave without pay.

Please note: The right to return to the original position cannot be waived unless this form is signed by both the employee and the facility/district/unit head (where the original position is located).

Name of Employee: _____ Employee ID #: _____

Title and PIN # of Original Position: _____ Facility: _____

Title and PIN # of Alternate Position: _____ Facility: _____

My signature and check (√) below certifies one of the following elections:

- ☐ I wish to waive my right to return to my original position. I understand that this right cannot be waived unless the facility/division/unit head indicates concurrence by signing below.

- ☐ I want to be returned to my original position in the event I am medically able to perform the essential job duties of my original position prior to the end of the one year after the start of leave without pay. I understand that in order to retain my right to be returned to my original position, I will furnish a medical statement from the authorized treating physician at least once every three months, and more often as required by the affected facility/unit head.

My signature below indicates that I understand that any right to the original position ends one year after the start of leave without pay.

Employee Signature: _____Date:_____

I agree to waive the employee's right to return to the original position

Appointing Authority Signature: _____Date: _____

Distribution: Original to Human Resources Benefits Unit (workers' compensation file)
Copy to employee
Copy to facility/unit(s)

(R 08/24)