



EMPLOYER'S NOTICE OF TERMINATION OF DISABILITY OR TRIAL WORK/LIGHT DUTY PERIOD

IMRF Form 5.45 (Rev. 11/09)

- Complete and send this form to IMRF promptly when a member either returns to work or begins a trial work period.

MEMBER'S LAST NAME	FIRST	MIDDLE INITIAL	SOCIAL SECURITY NUMBER
			_____ - _____ - _____
EMPLOYER NAME			EMPLOYER IMRF I.D. NUMBER

TERMINATION OF DISABILITY

- Member returned to work full duty (**no restrictions**) on _____ Date
- A physician, Dr. _____, certified that the member was able to return to work on _____ Date
Name

Attach a copy of the Physician return to work release form.

TRIAL WORK/LIGHT DUTY PERIOD INFORMATION

- Did member return to work on a trial basis (**reduced/modified work hours or days**)?
- Yes, member started a trial work period on _____ Date
- No
- Did member return to work on light duty (**modified position**)?
- Yes, member started a light duty work period on _____ Date
- No
- SLEP* Employee** — employee is returning to work in a: SLEP Position NON-SLEP Position (*check one*)
(**Sheriff's Law Enforcement Personnel*)
- Member started working for another employer on _____ Date
- Other: _____

Attach a copy of the Physician Return to Work Release form.

SIGNATURE OF AUTHORIZED AGENT	DATE
TITLE	TELEPHONE NUMBER () _____
EMAIL ADDRESS _____	FAX NUMBER () _____

Illinois Municipal Retirement Fund

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