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

Exhibit 5H

IMRF Form 5.45 (Rev. 05/2013)

This form to be submitted promptly when a member returns to work or begins a trial work/light duty period.

NOTE: **You may also submit Form 5.45 online via IMRF Employer Access.**

MEMBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	(JR.SR.II,ETC)	SOCIAL SECURITY NUMBER
Rowe	James	J.		000 - 00 - 0000

EMPLOYER NAME	EMPLOYER IMRF I.D. NUMBER
City of Anywhere	00000

SECTION 1 - PHYSICIAN'S RELEASE

A physician, Dr. Joe Medic (PHYSICIAN'S NAME), certified that the member was able to return to work on 6/26/2013 (MM/DD/YYYY). **Copy of the Physician's return to work release form MUST be attached to form.**

IMRF Member returned to work to (check one):

- [X] **FULL DUTY** *(With no restrictions and normal working hours. Do NOT fill out Section 2. Proceed to Section 3.)*
- [ ] **TRIAL WORK/LIGHT DUTY Period/OTHER** *(Section 2 MUST be filled out.)*

SECTION 2 - RETURN TO WORK INFORMATION *(Please select ONE option below and provide information as needed.)*

- [ ] **TRIAL WORK PERIOD:** Member returned to work on a trial basis; *the member is working a reduced or modified schedule in terms of work hours or days per week.* **Provide trial work period start date below.**

  Member started Trial Work Period on _____. (MM/DD/YYYY)

- [ ] **LIGHT DUTY PERIOD:** Member returned to work on a light duty basis; *the member is working normal/full working hours, but has medical restrictions.*

  Member started Light Duty Period on _____. (MM/DD/YYYY)

- [ ] **MEMBER NO LONGER EMPLOYED/NO RETURN TO WORK:** Member no longer working for the IMRF employer named above.

  Member started working for another employer on: _____ (MM/DD/YYYY)

- [ ] **OTHER:** Please describe below the return-to-work situation for the member, if it does not fit into one of the options listed above.

  _____

- [ ] **SLEP MEMBER:** Sheriffs' Law Enforcement Member is returning to work in a *(check one)*:

  _____ SLEP Position _____ NON-SLEP Position

SECTION 3 - AUTHORIZED AGENT'S CERTIFICATION

AUTHORIZED AGENT'S NAME (Please print.)	TITLE
Alice Agent	Business Manager
DAYTIME TELEPHONE NUMBER (with Area Code)	FAX NUMBER (with Area Code)
(000) 000 - 0000	(000) 111 - 2222
EMAIL ADDRESS	
aagent@cityofanywhere.com	
SIGNATURE OF AUTHORIZED AGENT	DATE (MM/DD/YYYY)
X Alice Agent	06/26/2013

NOTE: Provide complete and accurate information. Incomplete or inaccurate information may delay claims processing.

Illinois Municipal Retirement Fund
2211 York Road Suite 500 Oak Brook, IL 60523-2337
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