



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 Rowe	FIRST NAME James	MIDDLE INITIAL J.	(JR.SR.II,ETC)	SOCIAL SECURITY NUMBER 000 - 00 - 0000
EMPLOYER NAME City of Anywhere				EMPLOYER IMRF I.D. NUMBER 00000

SECTION 1 - PHYSICIAN'S RELEASE

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

IMRF Member returned to work to (check one): ☒ **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.

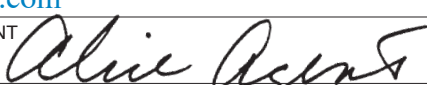
Member started working for another employer on: _____
(MM/DD/YYYY)

☐ **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.) Alice Agent	TITLE Business Manager
DAYTIME TELEPHONE NUMBER (with Area Code) (000) 000 - 0000	FAX NUMBER (with Area Code) (000) 111 - 2222
EMAIL ADDRESS aagent@cityofanywhere.com	
SIGNATURE OF AUTHORIZED AGENT X 	DATE (MM/DD/YYYY) 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

Member Services Representatives 1-800-ASK IMRF (1-800-275-4673) Fax: (630) 706-4289

www.imrf.org