Return to Work Release

A. To be completed by Employee

Employee Name:_____ **University ID:** _____

Supervisor Name:_____

Phone number where employee can be reached before returning to work:_____

Treating Health Care Provider's Name: _____

B. To be completed by Employee's Health Care Provider

The employee may have been given the essential physical functions and/or a description of their position. If not, please visit with the employee regarding the duties of their current job.

Please indicate if the employee can return to work: ☐ Yes ☐ No

If yes, please indicate the date the employee is released to return:_____

If yes, does the employee have any restrictions to return to work? ☐ Yes ☐ No

Please describe restrictions:

Health Care Provider Name (Please Print)**:** _____

Health Care Provider Signature: _____ **Date:** _____

Please complete this form and fax to Human Resource Services at 319-273-2927.

Note to Health Care provider: To comply with The Genetic Information Nondiscrimination Act of 2008 (GINA), please do not provide any genetic information when responding to this request for medical information. "Genetic Information" includes and individuals 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.

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