Return to Work Release

Section I: Completed by Employee

Employee Name: ____________________ University ID: __________

Home Phone Number: __________ Supervisor Name: ____________________

Treating Healthcare Provider's Name: ______________________________

Section II: Completed by Healthcare Provider

The above-named employee may have provided you the essential job functions and/or a description of their position. If not, please visit with the employee regarding the duties of their current job or contact our office for a copy of their job description prior to completing this form.

1. Has employee reached the end of their healing period?

- ☐ No ▸ If **NO**, when will employee's return to work status be evaluated? ______________
- ☐ Yes ▸ If **YES**, proceed to the next question.

2. Is employee able to return to work and perform the essential functions of their job?

- ☐ No ▸ If **NO**, sign and date this form and return to HRS.
- ☐ Yes ▸ If **YES**, proceed to the next question.

3. Please identify employee's return to work date: __________ and any restrictions/duration:

- ☐ **Regular** work schedule with no restrictions.
- ☐ **Regular** work schedule with the following restrictions: ____________________

  ____

  Date employee may resume regular duties: ____________________
- ☐ **Reduced** work schedule required by this condition beginning __________ through __________ with the following restrictions: ____________________

  ____

  Date employee may resume regular work schedule and duties: ______________

Healthcare Provider Printed Name: ______________________________

Healthcare Provider Signature: ____________________ **Date:** __________

Note: Please return completed form to: UNI Human Resource Services, **Fax: 319.273.2430**

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