HR Benefits

Return to Work Release

A. To Be Completed by Employee

Employee ID

Employee Name

Employee Home Phone

Supervisor Name

Health Care Provider Name

Health Care Provider Address

Health Care Provider Phone Fax

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 discuss with the employee the duties and requirements of his/her current job.

Indicate if the employee can return to work ☐ Yes ☐ No

If yes, employee release date

If yes, does employee have any restrictions? ☐ Yes ☐ No

Explanation of restrictions:

Health Care Provider Name (Please Print) ______________________________

Health Care Provider Signature ______________________________

Date ______________

Please complete this form and fax to James Madison University Human Resources at 540/568-7916.