HUMAN RESOURCES
HR

# 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.**