Return to Work Authorization

To the Employee: This form documents that your health care provider is authorizing you to return to work from your Medical Leave on the date specified below. When your health care provider informs you that you are able to return to work, please give this form to him or her to complete. Submit the completed form to the Benefits Team **before** the day you return to work.

Employee Name: _____ **Employee Work Location:** _____

To be completed by the employee's health care provider:

2. **Return to Work Date:** I certify that the above-named employee is able to return to work and resume performing the functions of his or her position on _____ /_____ /_____
   Month ***Day*** ***Year***

3. **Restriction(s) -- please check one:**

☐ The employee is released to return to work with no restrictions

☐ The employee is released to return to work subject to the following restriction(s):

Restriction(s) end on _____ /_____ /_____
Month ***Day*** ***Year***

_____ _____
Signature of Health Care Provider **Date**

_____ _____
Name of Health Care Provider **Phone Number of Health Care Provider**

_____
Address of Health Care Provider