Return to Work Form

Medical authorization from the health care provider is required for employees returning to work from FMLA/medical leave. This form should be returned to Ohio University Human Resources at least 3 business days prior to the return-to-work date. **All fields are required.**

Employee Section

Employee Name/Patient: (Last, First) _____

Job Title: _____

Date of Injury/Illness: _____

OHIO Employee ID or OHIO E-mail: _____

Health Care Provider Section

☐ Return to work at full duty, **with NO restrictions effective**: _____
Date

☐ Return to work **with the following restriction/s effective**: _____
Date

Expected duration of restriction/s is: _____

Please describe any specific restrictions relative to performing the employee's duties:

☐ Full-Time **OR** ☐ Part-Time: _____ hours per day or _____ per week

Employee has a return appointment on (date) and (time) _____ at _____
Date Time

_____ _____
Health Care Provider Signature Health Care Provider Name Printed

_____ _____ _____
Date of Signature Phone (include area code) Fax

_____
Street Address, City, State and Zip Code

Fax completed form to:		**Mail to:**
740-597-1337 Attn: Records and Leaves Manager	**-or-**	Ohio University Employee Service Center Grosvenor Hall 324 1 Ohio University Athens, OH 45701