



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:

740-597-1337

Attn: Records and Leaves Manager **-or-**

Mail to:

Ohio University Employee Service Center

Grosvenor West 103

1 Ohio University

Athens, OH 45701