



Return to Work and Medical Release Form

Name: _____ Date: _____

Department: _____ Employee ID: _____

I understand that I am being released to return to work on _____ (Date)

without restrictions

with restrictions as indicated below

I understand that if my restrictions related to my medical condition substantially limit my ability to perform the essential duties of my job, my return to work date may be delayed.

Employee Signature / Date

To Be Completed by Healthcare Provider:

(Employee Name) _____ may return to work at Youngstown State University to perform his/her job position as _____

Effective (date) _____.

Please indicate:

Without restrictions

With restrictions as noted below:

Restrictions are needed through: _____ (specific date)

Signature of Healthcare Provider & Date Signed: _____

Printed Name of Healthcare Provider: _____

Address: _____

Phone number: _____ Fax Number: _____

Please return to:
Youngstown State University Human Resources
One University Plaza, Youngstown, OH 44555
Fax: (330) 941-3716