

Return to Work and Medical Release Form

I understand that I am being released to return to work on	I understand that I am being released to return to work on	Name:	Date:
without restrictions with restrictions as indicated below 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	without restrictions with restrictions as indicated below 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	Department:	Employee ID:
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 Youngstow State University to perform his/her job position as Please indicate: Without restrictions	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: Address:	_	(Date)
To Be Completed by Healthcare Provider: (Employee Name) may return to work at Youngstow State University to perform his/her job position as effective (date) Please indicate: Without restrictions	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	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 Name) may return to work at Youngstow 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:	(Employee Name) may return to work at Youngstown State University to perform his/her job position as effective (date) Please indicate: Without restrictions	Employee Signature	Date
State University to perform his/her job position as	State University to perform his/her job position aseffective (date) Please indicate: Without restrictions	To Be Completed by Healthcare Provide	ler:
effective (date) Please indicate: Without restrictions	effective (date) Please indicate: Without restrictions	(Employee Name)	may return to work at Youngstown
Please indicate: Without restrictions With restrictions as noted below: Restrictions are needed through: Signature of Healthcare Provider: Printed Name of Healthcare Provider:	Please indicate: Without restrictions With restrictions as noted below: Restrictions are needed through: (specific date) Signature of Healthcare Provider: Printed Name of Healthcare Provider:	State University to perform his/her job pos	sition as
Without restrictions With restrictions as noted below: Restrictions are needed through: (specific date) Signature of Healthcare Provider: Printed Name of Healthcare Provider:	Without restrictions With restrictions as noted below: Restrictions are needed through: (specific date) Signature of Healthcare Provider: Printed Name of Healthcare Provider:	effective (date)	·
Restrictions are needed through: (specific date) Signature of Healthcare Provider: Printed Name of Healthcare Provider:	Restrictions are needed through: (specific date) Signature of Healthcare Provider: Printed Name of Healthcare Provider:	Please indicate:	
Signature of Healthcare Provider: Printed Name of Healthcare Provider:	Signature of Healthcare Provider: Printed Name of Healthcare Provider: Address:	☐ Without restrictions	☐ With restrictions as noted below:
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Printed Name of Healthcare Provider:	Printed Name of Healthcare Provider:	Restrictions are needed through: _	(specific date)
	Address:	Signature of Healthcare Provider:	
Address:		Printed Name of Healthcare Provider:	
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Phone number: Fax Number:		Phone number:	Fax Number:

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