Health Care Provider Release to Return to Work Certificate of Illness

Thank you for evaluating our employee, ____

ASU ID (**10 Digit Number**):____

Was this a work-related injury or illness? **Yes** ☐ **No** ☐

Date of Illness or Injury:____
MM/DD/YYYY

1) This employee may return to full duties without restrictions on ______________________________
MM/DD/YYYY

OR

2) If, in your medical opinion this employee is not capable of performing essential functions (attached), every effort will be made to place this employee in a job that will accommodate the restriction(s) you find medically necessary due to the injury/illness of _______________.
MM/DD/YYYY

Is employee able to return to fulltime or part-time work? **Full-time** ☐ **Part-time** ☐

Please indicate restriction(s) below and whether it is a permanent restriction.
Are these restrictions permanent? **Yes** ☐ **No** ☐

Duration of Restrictions: Beginning _____________ **Ending** _________________
MM/DD/YYYY **MM/DD/YYYY**

Lifting_____________________________	Bending___________________________
Kneeling___________________________	Stooping__________________________
Twisting___________________________	Standing__________________________
Walking____________________________	Sitting____________________________
Climbing___________________________	Reaching__________________________
Other______________________________	Repetitive Motion__________________

Anticipated date employee can return to full unrestricted duty. ___________________________
MM/DD/YYYY

Comments: **(DO NOT PROVIDE ANY CONFIDENTAL MEDICAL INFORMATION)**

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____

Print Health Care Provider Name ____________________

Health Care Provider Signature ____________________ **Date Signed (MM/DD/YYYY)**

Address ____

Telephone Number ____________________ **Fax Number** ____________________

Return completed form to: Arizona State University, HR Benefits Design & Management
P.O. Box 875612, Tempe, Arizona 85287-5612 OR **Fax to (480) 993-0007**
For further information, please call (480) 727-9900.

Give copy to Employee: Required to provide a copy of this Release to the Department and/or Supervisor.