Health Care Provider Release To Return to Work or Certificate of Illness or Injury

Form instructions

Health care provider completes all sections of the form and returns to employee.
Employee submits completed form to supervisor prior to return to work date.

Employee information — print

Name — first, middle initial, last: _____ ASU ID — 10-digit number: _____

Date of Illness or Injury — mm/dd/yyyy: _____ Was this a work-related injury or illness? ☐ Yes ☐ No

Work Status — Complete A or B.

A. ☐ The employee may return to full duties **without** restrictions on — mm/dd/yyyy: _____

B. ☐ The employee may return to work **with** restrictions indicated below on — mm/dd/yyyy: _____

- **Anticipated date employee can return to full unrestricted duty — mm/dd/yyyy:** _____
- Is the employee able to return to work full time? ☐ Yes ☐ No
- Is the employee able to return to work part time? ☐ Yes ☐ No
- How many hours can the employee work within a 24-hour period? _____hours
- How many days can the employee work within a five-day work week? Check one: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Restrictions or limitations

Check one	Description	Temporary–T Permanent–P	Duration of restriction — mm/dd/yyyy	
			From	To
☐ Yes ☐ No	Lifting Weight limitation _____ lbs.	☐T ☐P		
☐ Yes ☐ No	Walking _____ minutes _____ hours	☐T ☐P		
☐ Yes ☐ No	Sitting _____ minutes _____ hours	☐T ☐P		
☐ Yes ☐ No	Standing _____ minutes _____ hours	☐T ☐P		
☐ Yes ☐ No	Repetitive motion _____ minutes _____ hours	☐T ☐P		
☐ Yes ☐ No	Kneeling	☐T ☐P		
☐ Yes ☐ No	Stooping	☐T ☐P		
☐ Yes ☐ No	Climbing	☐T ☐P		
☐ Yes ☐ No	Bending	☐T ☐P		
☐ Yes ☐ No	Reaching	☐T ☐P		
☐ Yes ☐ No	Twisting	☐T ☐P		
☐ Yes ☐ No	Maintain regular business hours	☐T ☐P		
☐ Yes ☐ No	Attend and participate in meetings	☐T ☐P		
☐ Yes ☐ No	Concentrating	☐T ☐P		
☐ Yes ☐ No	Interacting with others	☐T ☐P		
☐ Yes ☐ No	Supervise and instruct staff	☐T ☐P		
☐ Yes ☐ No	Receive and provide training	☐T ☐P		
☐ Yes ☐ No	Seeing	☐T ☐P		
☐ Yes ☐ No	Hearing	☐T ☐P		
☐ Yes ☐ No	Other	☐T ☐P		

Health care provider comments

Health care provider information

Provider name:	Signature:
Address:	Date — mm/dd/yyyy:
Telephone:	Fax: