National UNIVERSITY | HUMAN RESOURCES

Health Care Provider Statement of Medical Release to Return to Work

EMPLOYEE: PLEASE FILL OUT THIS SECTION AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER.	
Employee:	Date:
Employee Position:	
Patient's Authorization: I authorize the Company's designated representative to contact my physician(s) to confirm any information provided regarding my physical or mental fitness to return to work. I authorize my physician(s) (or his/her representative) to release any information related to my fitness to return to work.	
Employee Signature:	Date:

HEALTH CARE PROVIDER: PLEASE FILL OUT THIS SECTION AND RETURN AS SHOWN BELOW.
Please specify the date you last examined the patient (employee):
Is this patient (employee) physically and mentally fit to return to work and perform the essential duties of his/her position with or without accommodation? ☐ Yes ☐ No
Date patient (employee) is released to return to work:
Please describe any work-related physical and/or mental limitations and provide a duration for these limitations.
If the employee needs an accommodation to enable him/her to perform the essential functions of the position, please describe the type of accommodation and the expected duration.
Please utilize this space for any additional information to be provided as needed.

Name of Health Care Provider:		
Specialty:		
Signature of Health Care Provider:	Date:	Address:

As required by National University Policy please provide this form to confidentialbenefits@nu.edu prior to returning to work.