Arizona State University

Health Care Provider Release to Return to Work
Certificate of Illness/Injury

Form instructions

Health care provider: Complete Section B and fax to 480-993-0007 ATTN:
Employee: Complete Section A and submit to to OHR Benefits 10 (ten) business days prior to Return to Work

Section A: Employee information - PRINT

Employee name (first, last):

Employee ID (10-digit number) :

Department number:

Department name:

Section B: Work status

Date of illness or injury:

Work-related illness or injury: ☐ Yes ☐ No

Employee may return to full duties **WITHOUT** restrictions on (mm/dd/yyyy):

OR

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 full-time work? ☐ Yes ☐ No
- Is the employee able to return to part-time work? ☐ Yes ☐ No
- How many hours can the employee work in a 24-hour period? hours
- How many days can the employee work in a five-day work week? days

Limitations or restrictions description	Duration of restrictions		Temporary or permanent
	Start	End	

Health care provider comments

Health care provider information

Provider name:

Signature:

Address:

Practice:

Date:

Phone:

Fax: