



Medical Release to Return to Work Form
(to be completed by Health Care Provider)

ECU Department of Human Resources-Benefits
210 East 1st Street, Greenville, NC 27858 | Mail Stop: 205 | Phone: 252-328-9887 | Fax: 252-328-9918

ATTENTION: EMPLOYEE

Have your Health Care Provider review your attached job description and ask him/her to complete this form. Return the completed form to the HR Benefits Department at least two days prior to returning to work.

If you believe you need reasonable accommodations to return to work, please contact the University's ADA Coordinator by phone at (252) 737-1016 or by email at ada-coordinator@ecu.edu.

ATTENTION: HEALTH CARE PROVIDER

Please review the attached job description for this employee, complete this form, and return it to the patient.

Patient/Employee Name: _____

Please check one of the following:

The patient is able to work a full, regular schedule with no restrictions beginning _____.

The patient is able to work a regular schedule beginning _____ with the restrictions indicated below.

The patient is able to return to work on a reduced schedule for _____ hour(s) a day from _____ through _____.

Please indicate restrictions, if any, below for:

Standing (number of hours): _____

Walking (number of hours): _____

Sitting (number of hours): _____

Lifting (number of pounds): _____

Carrying (number of pounds): _____

Use of hands (repetitive motions, pushing, pulling): _____

Other Restrictions: _____

Patient needs follow-up before being released to a full, regular duty schedule. Follow-up appointment is scheduled for _____.

No additional follow-up is required and patient is able to resume a full, regular schedule with no restrictions on _____.

Provider's Name and Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone: _____ Fax: _____

Signature of Health Care Provider: _____ Date: _____