THE UNIVERSITY OF KANSAS
Human Resource Management

# Return to Work Authorization form

Statement releasing employee to return to work following a medical absence

**Section I: for completion by employee**

Name: ______________________________________________________________________
First                                    Middle                                    Last

Department: _________________________________________________________________

**Note to employee: If you believe you have a medical condition that is affecting your ability to perform the essential functions of your job, you may contact the ADA Resource Center for Equity & Accessibility at (785)864-4946 or hrdept@ku.edu.**

**Section II: for completion by Health Care provider**

Provider's name and business address:_____________________________________________

Type of practice/medical specialty: _______________________________________________

Telephone: (______)__________________________ Fax: (______)__________________________

Return to Full Duty

Date Employee is released to return to **full duty and no work restrictions**: ______________________

Return with Work Restrictions

Date Employee is released to return work **with restrictions**:_________________________________

Work Restrictions:

_____________________________________________________________________________

_____________________________________________________________________________

Duration of above listed medical restrictions:______________________________________________
(if date not known, please provide the date of the next appointment)

Signature of Health Care Provider:_________________________________ Date:________________

**Submit this completed form to Human Resource Management**