

Healthcare Provider Statement of Medical Release to Return to Work

FORM MUST BE RETURNED TO GW BENEFITS
PRIOR TO YOUR RETURN TO WORK DATE

GW Benefits
benefits@gwu.edu
(571) 553-8382

THE GEORGE
WASHINGTON
UNIVERSITY
WASHINGTON, DC

How to Complete This Form

- Step 1:** Please complete the first section of this form and submit to your healthcare provider for completion of the second section.
- Step 2:** Either you or your healthcare provider must return the completed and signed form to GW Benefits via email at timeoff@gwu.edu or fax at (571) 553-8385 prior to your return to work. If a return to work authorization is not received in a timely fashion, your return to work may be delayed.

Employee: Please complete this section and forward form to your healthcare provider.

Employee name _____ Date _____

Employee position _____ GWID _____

Patient's Authorization:

I authorize the George Washington University'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 or her representative, to release any information related to my fitness to return to work.

Employee signature _____ Date _____

Healthcare Provider: Please complete this section and return form to employee.

Date you last examined the patient (employee) _____

Please indicate the status of the employee's release to return to work:

- ☐ Cannot return to work at this time.
- ☐ Can return to work on _____ (enter date) with the following restriction(s):

Can return to work on _____ (enter date) with no restrictions

Name of healthcare provider _____ Specialty _____

Healthcare provider signature _____ Date _____

Healthcare provider phone number _____