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
timeoff@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 timely, your return to work may be delayed.

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

Employee Name: ______________________________ GWID: ______________

Job Title/Position: ______________________________

Employee Authorization:

I authorize the George Washington University's designated representative to contact my healthcare provider(s) to confirm any information provided regarding my physical or mental fitness to return to work. I authorize my healthcare provider(s), or healthcare provider's representative, to release any information related to my fitness to return to work.

Employee Signature: ______________________________ Date: ______________

Healthcare Provider: Please complete this section and return the form to the 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 restrictions:

____

____

____

☐ Can return to work on ____________ (enter date) with no restrictions.

Healthcare Provider Name: ______________________________ Specialty: ______________

Healthcare Provider Signature: ______________________________ Date: ______________

Healthcare Provider Phone Number: ____________________