RETURN TO WORK RELEASE FORM

Office of Human Resources
500 W. University Ave.
El Paso, TX 79968
Fax #: (915) 747-5815
benefits@utep.edu

Employee: Please fill in the top portion of this form and take to your Health Care Provider for completion. This form must be provided to the Office of Human Resources prior to your return to work.

_____ _____
Employee Name (Last, First) EMPLID

_____ _____
Department Job Title

Health Care Provider: Please provide the following information regarding the above employee's return to work.

Is the employee able to resume working? ☐ No ☐ Yes, without restrictions ☐ Yes, with restrictions

Return to Work Effective Date: _____

Please list any restrictions or functional limitations which employer should consider:

_____

_____

_____

The restrictions will be: ☐ Permanent

☐ Temporary, until (date): _____

☐ Temporary until re-evaluated on (date): _____
(New Return to Work form will be required)

Name of Health Care Provider: _____

Specialty: _____

Business Address: _____

Telephone Number: _____

Signature of Health Care Provider: _____ Date: _____

This form helps gather return to work information and minimize release of medical information to a supervisor when returning from a leave of absence for an employee's own medical condition. This form is submitted by the employee to the Office of Human Resources. For information about workplace accommodations, contact the University's Equal Opportunity Office at (915) 747-5662 or email eoaa@utep.edu. You may be entitled to know what information UT El Paso collects about you. You may review and have UT El Paso correct this information according to procedures set forth in UT System Administration UTS139. See Texas Govt. Code, sections 552.021, 552.023, and 559.004 for pertinent guidance.