HUMAN RESOURCES
VIRGINIA TECH

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Return to Work Release

Employee Name: First Middle Last

Based on your evaluation, the employee can (check appropriate box below):

☐ Return to work *Full-Time, Full Duty* without any restrictions. Effective Date: _____.

☐ May not return to work at this time. Date & Time of next appointment: _____.

***Any work restrictions must be considered for temporary accommodations under the Americans with Disabilities Act, as amended in 2008. If selecting any of the three options below, Virginia Tech's ADA and Accessibility Services Medical Information Request Form for Return to Work Restrictions must be completed and returned with this form. (Both ADA and Accessibility Services and the Return to Work Manager will work with the department and employee to negotiate potential workplace accommodations related to restrictions, prior to returning):**

☐ *Return to work *Part-Time*: Effective Date: _____
Employee may work _____ hours per day and work _____ days per week.

☐ *Return to work *Full-Time with permanent restrictions*.

☐ *Return to work with temporary restrictions.

Physician Name:

Physician Signature: Date: