OFFICE of HUMAN RESOURCES
AMERICAN UNIVERSITY • WASHINGTON, DC

# FACULTY/STAFF RELEASE TO RETURN TO WORK

I certify that _____ is able to return to work on _____.
**Faculty/Staff Name** **Date**

☐ Full Duty – no restrictions

☐ *Return to Work – with restrictions _____ duration

*Please list restrictions in detail.

_____

_____

_____

Physican's signature required

_____ _____
Physician Signature Date

_____ _____
Physician Full Name Phone

_____
Address

_____
City, State Zip

**Instructions for Faculty/Staff Member**

Submit this completed form to the AU FMLA-Disability Team in Human Resources (ph. 202-885-3400) before you return to work. You will not be permitted to return to work without a release from your physician.

Fax to 202-885-1182 or scan and email to fmla-disability@american.edu.