

## **Fitness for Duty Release Form**

This form should be completed by your attending physician prior to your return to work. Please submit the completed form to the Human Resources Department. The information requested is confidential and will be used only to verify the employee's medical release to return work.

| Employee Name:   | ID#:                     |
|--|--------------------------|
| Physician's Name:  |                          |
| Address:   | -<br>-                   |
| Phone Number:  | -                        |
| The employee is physically able to return to work on restrictions.       | , without<br>(Date)      |
| The employee is able to return to work on restrictions will be lifted on | , with restrictions. The |
| (Date) Please list the restrictions below:                               |                          |
|  |                          |
|  |                          |
|  |                          |
| Physician's signature:   | Date:                    |

Please mail or direct form to:

Department of Human Resources
Attn: HR DIRECTOR/REPRESENTATIVE
1000 ASU Drive, 390
Alcorn State, MS 39096-7500