VANDERBILT UNIVERSITY
MEDICAL CENTER

Submit via Secure eFax:
615-343-2176

Request to Return from Medical Leave of Absence

To be completed by employee

Section 1

Employee's name: _____

Employee ID #: __ __ __ __ __ __ __

Supervisor's name: _____

Department: _____

Healthcare Provider's Statement

Section 2

This is to certify that _____ may return to work on _____.
(name of patient) (date)

Restrictions or limitations?

☐ None

☐ Yes

Restrictions: _____

End Date of restrictions: _____ (**if unknown, please list date of next follow up appointment)**

Print name and phone number of provider: _____

Provider's signature: _____ Date: _____

Section 3

This form must be completed **prior to returning to work.** Provide completed form to your supervisor for signature. Once faxed to HR, please retain copy of return form for your records.

Return form to HR for archiving by secure fax 615-343-2176

Supervisor signature: _____