Standard Insurance Company

Reset

Prior to returning to work
Fax to: 571.553.8385 or
Email to: benefits@gwu.edu

Return to Work Authorization

To Be Completed By Employee

Patient Name	Date of Birth
Group Name **The George Washington University**	Group Policy No. **649391**

I authorize Standard Insurance Company to share information collected with this form with my employer for purposes of evaluating my return to work status.

Patient's Signature	Date

To Be Completed By Health Care Provider

NOTE TO HEALTH CARE PROVIDER: If the employee has provided you with a list of his/her essential job functions or his/her job description, please answer these questions based upon that information. If the employee has not provided you with that information, please answer these questions based upon the employee's own description of his/her job functions. **Limit your responses to the condition(s) for which the employee has been on leave.**

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Have you been provided with a list of essential job functions or job description to consider in your assessment of the employee's ability to return to work?

☐ Yes
☐ No

Is the above named employee fit to resume work functions?

☐ Yes, effective date:
☐ No

If no, please provide a brief description of any work restrictions and/or essential work functions the employee is not able to perform.

Name of Health Care Provider			
Address	City	State	ZIP
Phone No.	Specialty/Type of Practice		
Signature of Health Care Provider	Date		

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