HEALTHCARE RELEASE
College of Nursing

Health Science Campus MS1026
Collier Building 4430
3000 Arlington Avenue
Toledo, OH 43614-2598
419.383.5859

Return form to the Program Office. Course coordinators are notified that a release is on file. If clinical participation is in progress, the college will seek clinical site approval. The student will abide by the agency decision regarding involvement in patient care or other services.

Student Name:_____ Program: _____

I plan to return to class on this date: _____
☐ Full-time
☐ Part-time

I plan to return to clinical on this date: _____
☐ Full-time
☐ Part-time

Student Signature_____Date: _____

These sections must be completed by the healthcare provider (MD, DO, NP, PA) prior to return to the university for class and clinical. It is applicable for illness, injury, childbirth, communicable disease, or other conditions that preclude participation in class or clinical experiences.

Health Status:
☐ Recovered, able to return to class full-time on this date: _____
☐ Recovered, able to return to clinical full-time on this date: _____
☐Able to return to class withrestrictions on this date: _____
☐Able to return to clinical with restrictions on this date: _____

Restrictions _____ _____
☐ Date of next evaluation: _____
If clinical participation is in progress, the college will seek clinical site approval. The student will abide by the agency decision regarding involvement in patient care or other services.

Justification (by healthcare provider)
☐ The entire duration of the absence was justified for medical reasons Start date: _____
Stop date: _____

☐ I cannot justify the entire duration of the absence due to:

_____ _____

Healthcare Provider Signature_____Date: _____

Phone:_____License Number: _____
Address _____