NOVA SOUTHEASTERN UNIVERSITY | NSU Florida

MATRIX ABSENCE MANAGEMENT
A MEMBER OF THE TOKIO MARINE GROUP

Fitness-for-Duty / Return to Work Release Form

THIS FORM IS NOT REQUIRED FOR INTERMITTENT LEAVES OR LEAVES FOR FAMILY MEMBERS.

IMPORTANT — TIME SENSITIVE

This form must be completed by your **Health Care Provider** and submitted to your **Claims Examiner at least five business days prior** to your return to work date. Matrix fax number: 866-683-9548

Employee Name:	**Employee ID:**
Matrix Intake Number:	**Leave Request Date:**

TO THE EMPLOYEE: If you are returning to work with restrictions, you need to communicate with your employer to determine if reasonable accommodation(s) can be made for you to return to work. You must contact the HR Representative identified above as soon as restrictions are known, at a minimum **5 business days in advance of returning to work**, to ensure appropriate planning can take place.

Failure to submit this form may delay or prevent your ability to return to work.

On the day you return to work, check in with your Manager prior to reporting to work.

TO BE COMPLETED BY HEALTH CARE PROVIDER

The above-named employee is (please check one of the boxes below):

- ☐ Able to work **full duty (no restrictions) effective** (enter date): _____SKIP TO BOTTOM OF FORM.
- ☐ Able to return **with modifications effective** (enter date): _____COMPLETE ENTIRE FORM.

Employee work limitations or restrictions

Please address **ONLY** any physical and/or mental/behavioral limitations that:

- the employee has as a result of an impairment identified below **AND**
- relate to the performance of the duties of his or her employment position.

Examples of physical limitations: Lifting, bending, reaching, kneeling, sitting, standing, walking, pushing, pulling, use of hands or arms, exposure to heat or cold, etc. Include specific limitations such as the expected duration of each limitation or restriction, pound limits for lifting restrictions, or any other relevant information to help the employer understand your patient's limitations and what your patient needs to perform his/her job.

Examples of cognitive/mental/behavioral limitations: Concentration, memory, focus, oral or written communication, expressing thoughts, organization, multitasking, synthesizing information, exercising judgment, interacting with others, time management, flexibility with change management, etc. Include specific limitations such as the expected duration of each limitation or restriction, modifications to work place setting, and any other relevant information to help the employer understand your patient's limitations and what your patient needs to perform his/her job.

Health Care Provider: Identify limitations or restrictions, if any, on next page.

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Employee Name: **Employee ID:**

Identify each impairment causing limitations or restrictions:	**Identify the limitations or restrictions caused by this impairment (please be specific):**

Use additional page if needed.

If limitations are identified, provide estimated duration of restrictions and/or date of return to full duty (if applicable):

Comments:

Health Care Provider Name (PLEASE PRINT):

Address:

Telephone No: **Fax No:**

Field of Practice:

Signature of Health Care Provider:

Date of Signature: