NSU Office of Human Resources

BENEFITS WITH AN EDGE.

Return to Work Form

EMPLOYEE NOTICE

This form must be completed and submitted to your Benefits Team by email at **loa@nova.edu** or by fax to **954-262-6859** at least one day prior returning to work. Failure to do so, will delay your return to work.

THIS FORM IS NOT REQUIRED FOR INTERMITTENT , BONDING LEAVES AND/OR LEAVES TO CARE FOR A FAMILY MEMBER.

SECTION I—TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)

NSU ID NUMBER

LINCOLN CLAIM NUMBER

LEAVE END DATE

SECTION II—TO BE COMPLETED BY THE 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): MM DD YYYY

☐ Able to return to work with **restrictions** effective (enter date): **From** MM DD YYYY **To** MM DD YYYY

Comments:

SECTION IV—MEDICAL PROVIDER CONTACT INFORMATION

Health Care Provider Name (PLEASE PRINT):

Telephone No:

Fax No:

Health Care Provider's Signature:

Date of Signature: