**Return to Work Form**

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| **Patient / Employee Information** |
| **Patient / Employee Name:** |  | **Last 4 digits of SSN#**  |  |
| **Date of Condition / Injury:** |  | **Diagnosis/Treatment:** |  |

**The completed Return to Work Form must be received by Inotiv Benefits on or before your return date. The form may be emailed to** **usbenefits@inotivco.com** **or faxed to 765-807-7071.**

**\*\*TO BE COMPLETED BY ATTENDING PHYSICIAN\*\***

**[ ]** Employee may return to work with no restrictions on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(date)*.

**[ ]** Employee may return to work with the following restrictions listed below. Restrictions are in effect from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(dates only)*.



**[ ]** Employee is totally disabled and may not return to work from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(dates)*.

 Explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**[ ]** Is the employee on any prescriptions that would cause them any physical or mental impairment that would affect the patient’s ability to perform their job? **[ ]**  No **[ ]**  Yes,

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| **Physician Information** |
| **Physician Name:** |  | **Clinic / Facility Name:** |  |
| **Signature & Date:** |  | **Clinic / Facility Phone #:** |  |

*When completed, please return the completed form to the patient.*