Return to Work Form

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@inotiv.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)*.

Patient CAN Carry/Lift	None	1-4 Hours	5-8 Hours
Up to 10 LBS			
11-20 LBS			
21-50 LBS			
51-100 LBS			

Hand Restrictions	NO USE	USE RIGHT ONLY	USE LEFT ONLY	USE BOTH
OPERATE POWER TOOLS				
REPETITIVE WRIST				
ONE HAND WORK ONLY				

Patient's condition ALLOWS them to perform the following activities. (How many hrs each day)	Up to 2 Hours	Up to 4 Hours	Up to 6 Hours	No Restrictions
BEND				
TWIST/TURN				
REACH BELOW				
KNEE				
Reach above Shoulder				
PUSH/PULL				
CLIMB				
SQUAT/KNEEL				
Must SIT				
STANDING				
WALKING				
Crawl				
Grip/Squeeze/Pinch				

☐ Employee is totally disabled and may not return to work from _____ to _____ *(dates)*.
Explanation: _____
_____

☐ 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,

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

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