Date of Visit: _____ Return to Fax #: 812-228-5068

Healthcare Provider Name: _____

Phone Number: _____

Fax Number: _____

Patient Name: _____ Date of Birth: _____ (MM-DD-YYYY)

___ May Return to work without work restrictions as of _____ (MM-DD-YYYY)

___ Unable to work at this time until _____ (MM-DD-YYYY)

___ May work with restriction(s) listed below until _____ (MM-DD-YYYY)

† Standing † Walking/sitting
† Riding/driving † Overhead work
Not over ___ 1-5, ___ 6-10, ___ 11-15, ___ 16-20, _____ other times per hour)

† No prolonged (greater than 1 hour)
Requires _____ minimum break/hr
† Standing † Walking/sitting
† Riding/driving † Overhead work

† No lifting more than ___ pounds.
† No reaching below waist
† Limited reaching below waist. Specify: _____
† No bending/twisting at waist.
† Limited bending/twisting at waist Specify: _____
† No squatting/kneeling
† Limited squatting/kneeling Specify: _____
† Other: _____

Physician Print Name: _____

Physician Signature: _____

Date: _____