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)

- ☐ Seated work only
- ☐ Wear splint at all time
- ☐ No stair/ladder climbing
- ☐ No work above shoulder level using ___ arm(s).
- ☐ No push/pull with more than ____ pounds force.
- ☐ No repetitive:
  - ☐ 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: _____