MD 201 revised 10-27-05

MEDICAL SUPPORT FOR RETURN TO SERVICE OFF DUTY ILLNESS OR INJURY

Employee's Information:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
ID No: _____ Phone No: _____
Position: _____ Dept: _____

Physician's Information:

Name: _____
Address: _____
_____
City: _____ State: _____ Zip Code: _____
Phone No: _____ Fax No: _____

The doctor named above is authorized to provide the IHB RR any and all medical records regarding my illness or injury as it relates to my absence from work.
I authorize the IHB RR to contact my personal physician if further information is required.

_____ _____
Date Employee's Signature

PERSONAL PHYSICIAN'S RETURN TO WORK APPROVAL

_____ The above named employee may return to work without any restrictions on _____ (date)
_____ The above named employee may return to work with the following restrictions:

_____ No lifting over _____ lbs. _____ No repetitive kneeling, squatting _____ Must wear hearing protection
_____ No repetitive stooping, twisting _____ No prolonged standing, walking

Prognosis, other work restrictions, drug treatments (required), etc.: _____

_____ _____
Date Personal Physician's Signature

IHB MEDICAL DIRECTOR'S RETURN TO WORK APPROVAL

_____ The above named employee may return to work without any restrictions on _____ (date)
_____ The above named employee may return to work with the following restrictions:

_____ No lifting over _____ lbs. _____ No repetitive kneeling, squatting _____ Must wear hearing protection
_____ No repetitive stooping, twisting _____ No prolonged standing, walking

_____ _____
Date IHB Medical Director's Signature

NOTE: IHB's Medical Director may use IHB Form MD-100 for more detailed restrictions, etc. Same should accompany this form.

Return this form to the IHB Human Resources Department, 2721-161st Street, Hammond, IN 46323-1099, or fax this form to 219/989-4967.