



### MEDICAL SUPPORT FOR RETURN TO SERVICE OFF DUTY ILLNESS OR INJURY

*Employee's Information:*

*Physician's Information:*

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

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.**