**Return to Work Form**

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An important aspect of our company’s Return-to-Work program is returning an employee to work as soon as medically able after the date of injury or illness. Please provide the following information so that we can best determine the physical limitations of the employee, and if necessary, place the employee in a suitable temporary modified job.



|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Employer |  |  |  |  | Contact Person |  |
| **Athelas Institute, Inc** |  |  | **Tisha Mathes, HRM** |  |
|  |  |  |  |  |  |
| Employer Address |  |  | City | State | Zip Code |
| **9104 Red Branch Road** |  | **Columbia** | **Maryland** | **21045** |
|  |  |  |  |  |
| Employer Phone |  |  | Employer’s Insurance Carrier |  |
| **(410) 964-1241** |  |  | **Injured Worker’s Insurance Fund, IWIF** |  |
|  |  |  |  |  |
| Name of injured employee |  |  |  | Employee’s Social Security Number |
|  |  |  |  |  | **-** | **-** |
|  |  |  |  |  |  |
| Employees Phone |  | Date of Injury |  | Claim Number |  |
| **(** | **)** | **-** | **/** | **/** |  |  |
|  |  |  |  |  |  |  |
| Job Title |  |  |  | Type of injury |  |  |



*Please complete the following information and fax to 410-992-9989*

**Physician’s Evaluation**

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Diagnosis:



Treatment:



|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Worker is released to:** |  |  |  |  |  |  |  |
| full duty without limitations |  |  |  | effective (date) | / | / |  |
| modified duty | from (date) | / | / | through (date) |  | / | / |
| specify limitations |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |



|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  | from |  |  | through |  |
| modified hours |  |  |  | (date) |  |  | (date) |  |
| **Hours able to work in 24 hour** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** |
| **period:** |  |  |  |  |  |  |  |  |



Other functional limitations or modifications necessary in worker’s employment:



|  |  |  |  |
| --- | --- | --- | --- |
| Physician Signature | Date |  |  |
|  | **/** | **/** |  |
|  |  |  |
| Physician Name | Physician’s Phone Number |  |
|  | **(** | **)** | **-** |
|  |  |  |  |
| Physician Address | City | State | Zip Code |
|  |  |  |  |