



When replying, refer to: Customer Number
 Policy Number
 Policy Period

Dear Insured:

SUBJECT: WORKERS' COMPENSATION CLAIM INFORMATION

West Bend is pleased to provide you with ...

1. Workers' Compensation reporting tips that are helpful when you must report a work-related injury.
2. Employer's First Report of Injury or Disease forms.
3. Supervisor's Incident Report.
4. A description of our cost containment initiatives.

The following forms are also available and are helpful in returning your employee to work ...

1. **Job Analysis.** (WB 501) Use this form when working with the treating physician.
2. **Attending Physicians Return to Work Recommendations Record.** (WB 531) Send this with the injured employee to the initial treating doctor's appointment. You may ask the employee to return the form directly to you after initial medical treatment, or ask the doctor to fax it back to you.
3. **Return to Work Log.** (WB 603) Use this log as an efficient method to monitor and document the specific tasks your employees are performing while on light or modified duty.

We hope you find this information useful.

Sincerely,

Workers' Compensation Claim Department

WB 602 D 03 07

WORKERS' COMPENSATION REPORTING TIPS

– ATTENTION – YOU MAY BE FINED IF YOU DO NOT REPORT ON-THE-JOB INJURIES ON TIME

You must complete an Employer's First Report of Injury IMMEDIATELY after an on-the-job injury occurs and forward the report to your claims administrator. **You may be fined if you do not submit the report on time.**

Send, fax, call, or e-mail the initial loss report immediately, even if you do not have all the information about the injury.

- Do not wait for medical bills.
- Do not withhold the loss report because you believe the claim is questionable. Reporting a loss is not an admission of liability.
- Be sure to include the policy number on all correspondence.

Please mail, fax, call, or e-mail the report to:

West Bend Mutual Insurance Company Claims:

All States

Workers' Compensation Claims Department
West Bend Mutual Insurance Company
1900 S. 18th Avenue
West Bend, WI 53095
Phone: 877-922-5246
FAX: 888-926-9299 or 262-334-6378
e-mail: directconnect@wbmi.com

General Questions:

Phone: 800-236-5004 or 334-6430
e-mail: wccentral@wbmi.com

NSI Claims:

Workers' Compensation Claims Department
8401 Greenway Blvd., Ste 1100
Middleton, WI 53562
Phone: 800-760-9250
Fax: 877-434-9585
e-mail: nsiclaims@wbmi.com

Do not withhold the loss report for any reason. Send, fax, call, or e-mail it IMMEDIATELY after the injury occurs. **You may be fined** if the claims administrator cannot make the initial lost time payment because you failed to send the Employer's First Report of Injury on time.

If you fax or e-mail the report, please do not send it. If you need to notify your agent, please send your agent a photocopy of the report. Direct reporting saves time.

If you have any questions, please call your claims administrator.

HOW TO WRITE INJURY DESCRIPTIONS

The following instructions will help you avoid some common errors and save time when describing an injury on the First Report of Injury form.

For most accidents, you can describe what happened in one or two sentences. "He strained his lower back lifting a box." "She bruised her left knee when she fell on a wet floor." However, your descriptions must be specific. "Hurt back working" does not provide enough information.

Answer the following questions when describing an injury:

1. What part of the body was injured?

- Lower back
- Right forearm
- Upper right leg
- Third toe on left foot

2. How did the accident happen?

- Did the person fall?
- Did they twist their body as they got out of a chair?
- Were they moving or stationary when the accident happened?

3. Was the injured person carrying anything?

Even if it probably didn't cause the injury, we need to know if the person was carrying anything. For example, "Carrying broom, stepped wrong and twisted left ankle."

4. What specifically appears to have caused the accident?

If someone hurt their back lifting a box, say that. Don't say:

- Lifting a unit of material
- They hurt their back lifting product
- Lifting equipment

Avoid jargon or trade names for equipment. Explain precisely what they were doing.

- Lifting an air conditioner
- Pushing a cart
- Carrying magazines
- Bending over to pick up a wrench

If a machine caused the injury, tell us what kind.

- A grinder
- A shear
- A hoist

Again, avoid jargon or trade names.

5. What injury appears to have resulted?

- Strain
- Fracture
- Bruise
- Cut

Please be sure to include the injured person's birthdate or age and Social Security number. Also, indicate the geographical location of the accident (city, county and state).

INDIANA WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the state of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The worker's compensation insurance carrier or the administrator for:

(name of company)

is:

WEST BEND MUTUAL INSURANCE COMPANY

(name of carrier/administrator)

1900 SOUTH 18TH AVENUE

(mailing address)

WEST BEND, WISCONSIN 53095

(city, state, zip)

1-800-236-5004 or 262-334-6430

(telephone number)

WORKER'S COMPENSATION CLAIMS DEPARTMENT

(contact person)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

Worker's Compensation Board of Indiana
Ombudsment Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667



INDIANA WORKER'S COMPENSATION FIRST REPORT OF EMPLOYEE INJURY, ILLNESS

State Form 34401 (R10 / 1-02)

Please return completed form electronically by an approved EDI process.

FOR WORKER'S COMPENSATION BOARD USE ONLY		
Jurisdiction	Jurisdiction claim number	Process date

PLEASE TYPE or PRINT IN INK

NOTE: Your Social Security Number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

EMPLOYEE INFORMATION							
Social Security number	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown			Occupation / Job title		NCCI class code
Name (last, first, middle)			Marital status <input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown		Date hired	State of hire	Employee status
Address (number and street, city, state, ZIP code)					Hrs / Day	Days / Wk	Avg Wg / Wk <input type="checkbox"/> Paid Day of Injury <input type="checkbox"/> Salary Continued
Telephone number (include area code)			Number of dependents		Wage Per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month \$ <input type="checkbox"/> Year <input type="checkbox"/> Other		
EMPLOYER INFORMATION							
Name of employer			Employer ID#		SIC code	Insured report number	
Address of employer (number and street, city, state, ZIP code)			Location number		Employer's location address (if different)		
			Telephone number				
			Carrier / Administrator claim number		OSHA log number	Report purpose code	
Actual location of accident / exposure (if not on employer's premises):							
CARRIER / CLAIMS ADMINISTRATOR INFORMATION							
Name of claims administrator West Bend Mutual Insurance Company			Carrier federal ID number 39-0698170		Check if appropriate <input type="checkbox"/> Self Insurance		
Address of claims administrator (number and street, city, state, ZIP code) 1900 S. 18th Avenue, West Bend, WI 53095			<input checked="" type="checkbox"/> Insurance Carrier		Policy / Self-insured number		
Telephone number 800-334-5004		Fax number 262-334-6378	<input type="checkbox"/> Third Party Admin.		Policy period From _____ To _____		
Name of agent			Code number				
OCCURRENCE / TREATMENT INFORMATION							
Date of Inj. / Exp.	Time of occurrence <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Cannot be determined		Date employer notified	Type of injury / exposure			Type code
Last work date	Time workday began	Date disability began		Part of body			Part code
RTW date	Date of death	Injury / Exposure occurred on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of contact		Telephone number	
Department or location where accident / exposure occurred				All equipment, materials, or chemicals involved in accident			
Specific activity engaged in during accident / exposure				Work process employee engaged in during accident / exposure			
How injury / exposure occurred. Describe the sequence of events and include any relevant objects or substances.							Cause of injury code
Name of physician / health care provider							
Hospital or offsite treatment (name and address)					INITIAL TREATMENT <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinic / Hospital <input type="checkbox"/> Emergency Care <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Future Major Medical / Lost Time Anticipated		
Name of witness		Telephone number		Date administrator notified			
Date prepared	Name of preparer		Title	Telephone number			

An employer's failure to report an occupational injury or illness may result in a \$50 fine (IC 22-3-4-13).

INSTRUCTIONS

General Instructions:

1. Please enter information into all of the areas of the First Report form, except the boxes at the top right corner of the form which is for office use only.
2. Enter all dates in MM/DD/YY format.
3. Please return completed form electronically by an approved EDI process.
4. For answers to questions, please call (317) 232-3808.

Definitions:

AGENT NAME & CODE NUMBER: Enter the name of your insurance agent and his / her code number if known. This information can be found on your insurance policy.

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR EXPOSURE OCCURRED: List anything the employee was using, applying, handling or operating when the injury or exposure occurred. If the injury involves a fall, indicate any surfaces and / or objects the claimant fell on and where they fell from. Enter "NA" if no equipment, materials or chemicals were being used (e.g. *Acetylene cutting torch, metal plate, etc.*).

AVG WG/WK: Claimant's average weekly wage, calculated by totaling the latest 52 weeks of wages (*including overtime, tips, etc.*) and dividing by 52.

CLAIMS ADMINISTRATOR: Enter the name of the carrier, third-party administrator, state fund, or self-insured responsible for administering the claim.

CONTACT NAME / PHONE NUMBER: Enter the name of the individual at the employer's premises to be contacted for additional information (*i.e. Supervisor, HR Person, Nurse, etc.*)

DATE DISABILITY BEGAN: The first day on which the claimant originally lost time from work due to the occupational injury or disease or as otherwise designated by statute.

DEPARTMENT OR LOCATION WHERE ACCIDENT OR EXPOSURE OCCURRED: If the accident or exposure did not occur on the employer's premises, enter address or location. Be specific (*e.g. Maintenance, Client's Office, Cafeteria, etc.*).

EMPLOYEE STATUS: Indicate the employee's work status from the following choices: Full-time, Part-Time, Apprentice Full-Time, Apprentice Part-time, Volunteer, Seasonal Worker, Piece Worker, On-Strike, Disabled, Retired, Not Employed or Unknown (you may also abbreviate the above as follows: *FT, PT, AFT, APT, VO, SW, PW, OS, DI, RE, NE or UK*).

HOW INJURY / ILLNESS OCCURRED: Describe the sequence of events leading to the injury or exposure (e.g. Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, he brushed against the hot metal; Worker stepped to the edge of the scaffolding, lost balance and fell six feet to the concrete floor. The worker's right wrist was broken in the fall).

NCCI CLASS CODE: A four-digit code classifying the occupation of the claimant.

OCCUPATION / JOB TITLE: Enter the primary occupation of the claimant at the time of the accident or exposure.

PART OF BODY AFFECTED: Indicate the part of body affected by the injury / illness (*e.g. Right forearm, Low Back, etc.*).

REPORT PURPOSE CODE: 00 = Original First Report of Injury; 02 = Updated or Amended First Report.

RTW DATE (Return to Work Date): Enter the date following the most recent disability period on which the employee returned to work.

SIC CODE: This is the code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

SPECIFIC ACTIVITY EMPLOYEE ENGAGED IN DURING ACCIDENT / EXPOSURE: Describe the specific activity the employee was engaged in during the accident or exposure (*e.g. Cutting metal plate for flooring, sanding ceiling woodwork in preparation for painting*).

TYPE OF INJURY / ILLNESS: Briefly describe the nature of the injury or illness (*e.g. Contusion, Laceration, Fracture, etc.*)

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN DURING ACCIDENT / EXPOSURE: Enter "NA" if employee was not engaged in a work process, such as if walking down the hallway (*e.g. Building maintenance*).

SUPERVISOR'S INCIDENT REPORT

Injury (work related)
 Illness (work related)
 Property Damage
 Incident

Employee Name (First, Middle, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Employee Home Telephone Number		
Employee's Street Address						City		State	Zip	
Age	Birthdate Mo. Day Yr.		Job Title			Department				
Employee's Scheduled Work Week When Injured		Start Time AM PM	End Time AM PM	Hrs. Per Day	Hrs. Per Wk.	Days Per Wk.	Normal Full-Time Schedule for Injured's Work	Start Time AM PM	End Time AM PM	
Injury Date Mo. Day Yr.		Hour of Day AM PM		Last Day Worked Mo. Day Yr.		Start Date Mo. Day Yr.		<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work Mo. Day Yr. <input type="checkbox"/> Estimated Date of Return		

Did employee seek medical attention? Yes No If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will the employee complete a drug screening? Yes No

Names of Witnesses (Attach witness statements.)

1. _____ 2. _____

Injured Employee's statement of what happened. (Identify circumstances and equipment involved.)

How could this incident have been prevented?

What corrective action has been taken?

What is the injury/illness? (Be specific.)

Part of Body Affected

- Eye
- Head
- Neck
- Back
- Arm
- Shoulder
- Fingers
- Leg
- Knee
- Hip
- Foot
- Wrist
- Hand
- Toes
- Ankle
- Elbow
- Trunk (Other than back)
- Other

Type of Injury

- Cut/Abrasion
- Bruise/Contusion
- Foreign Object
- Burn
- Break
- Sprain/Strain
- Exposure
- Repetitive Motion
- Other

I believe that the answers to the above questions are true to the best of my knowledge.

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

Notified

WORKERS COMPENSATION COST CONTAINMENT INITIATIVES

West Bend Mutual Insurance Company participates in several medical cost containment initiative programs. The use of these programs helps reduce your workers' compensation expenses. A brief summary of each program is outlined below.

If you have any questions about any of the programs we offer, please call our Workers' Compensation Claim Department at 1-800-236-5004.

PHARMACY PROGRAM

This program is designed to provide discounts on workers' compensation prescriptions submitted by your injured employees. This service is provided by a national pharmaceutical management company using a network of retail pharmacies.

How the program works:

1. The injured employee files a workers' compensation claim with employer, seeks medical treatment, and receives a prescription from a physician.
2. The injured employee presents the prescription along with the temporary ID form to a participating pharmacy where the claim is electronically submitted by the pharmacy to our vendor.
3. Once West Bend receives notification of the claim from the employer, an employee-specific ID drug card is issued, along with a list of participating pharmacies and instructions on the use of the program.
4. The injured employee presents the ID drug card to a participating pharmacy for any future workers' compensation prescriptions.
5. High-cost/long-term-use medications are conveniently supplied through our vendor's mail service pharmacy.

DIAGNOSTIC TESTING PROGRAM

Using the services of a diagnostic management vendor, we can save money on any diagnostic test (i.e., CT scans, MRIs, EMGs, etc...) the treating doctor orders for injuries an employee sustains in a work-related injury. Our vendor will schedule the test, then notify the injured employee of the date and time. Once the test is performed, the films/x-rays will be forwarded to the referring physician.

To make this program successful, we ask that you encourage your employees to contact their West Bend claim representative as soon as they know a test will be ordered. We will handle it from there.

MEDICAL COST CONTAINMENT

Strong medical management brings about the early and safe return to work of your employees and reduces claim costs. To accomplish this, we contract with a medical bill review service. All of our medical provider charges (hospital, physician, physical therapist, chiropractor, and pharmaceutical) are verified for the appropriateness of the charge, and to determine if they adhere to state mandated fee schedules or local usual and customary (U&C) reimbursement levels. This process often reduces our medical expenses by 10-30%.

Another way we are containing costs is through the use of a PPO Network. The Preferred Providers have agreed to discount their billings for the treatment of your industrially injured employees. This in turn keeps your premium costs down.

Your support in encouraging your injured workers to use a PPO provider is important. It sends an important message to the medical care providers that we support them in their effort to offer quality, cost effective care to patients.

For a list of PPO's in your area, please visit our website, www.thesilverlining.com for a link to the PPO list. Click on "Claims" and then on "How to Report A Claim" for the link to our vendor.

QUALITY MEDICAL CARE (Applicable in Indiana and Iowa only)

As your workers' compensation insurer, we share your goal of providing quality medical care to your injured workers so that they may return to the work force as soon as possible. In Indiana and Iowa, the employer and its insurance carrier have the responsibility for providing reasonable and necessary medical care when there is an injury and the ability to choose which physician or other medical practitioner that will provide the service. **In other words, it is the employer and insurance carrier who select the physician to treat an injury, not the injured employee.** If the employee refuses to accept medical services as instructed by the carrier, the right to receive compensation may be suspended during the period of refusal.

It has been our experience that one of the most effective ways to carry out our mutual responsibilities under the Indiana and Iowa Workers' Compensation Laws for an injured worker is for you, as an employer, to designate a company physician who is authorized to treat work-related injuries. This designation should be part of our internal procedure for reporting on-the-job injuries. Each employee should be instructed, particularly when first hired, on how to report an on-the-job injury and what physician is authorized for treatment. It should be made clear that except in cases of an emergency, no other medical or chiropractic care is authorized and charges incurred for those services will not be honored. Many of our employers put this policy in writing and have the employee sign and date this document.

There are many benefits to this policy. First, injured employees know exactly where to go for medical care when needed. Second, a good working relationship is established between the physician, you as an employer, and us as an insurance company. We find we get prompt answers to our questions and are able to better manage both medical costs and claims for weekly benefits. Referrals, particularly when an independent medical exam is needed, are greatly simplified. Where rehabilitation is needed, company physicians can assist our rehabilitation nurses and our vocational counselors.

We will be happy to work with you in designating a company physician and helping you implement this program. Please feel free to call the Workers' Compensation Claim Department with any questions or comments.



**WEST BEND MUTUAL INSURANCE COMPANY
WORKERS' COMPENSATION PRESCRIPTION INFORMATION**

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name:	
Group #:	10602270
Member ID (SSN):	
Date of Injury:	
Claim Number:	
Processor:	myMatrixx
Bin #:	014211
Day supply is limited to 3 days for a new injury	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:
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Injured Worker:

West Bend has partnered with **myMatrixx** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. **myMatrixx** has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call **myMatrixx** toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling **myMatrixx** for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All other will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

AUTHORIZATION TO DISCLOSE NON-PUBLIC PERSONAL HEALTH INFORMATION AND WAIVER OF PRIVILEGE

TO: Patient Name:
Claim Number:
Birth Date:
Social Security No.:

I, _____, hereby authorize the above named health care provider to give to, release, and permit copies to be made of all health care records that are in your possession.

The health care records should be disclosed to any authorized representative of West Bend Mutual Insurance Company. West Bend Mutual Insurance Company is the insurer for the employer and acts as its agent for insurance purposes.

The purpose of the disclosure of these records is to aid West Bend Mutual Insurance Company's evaluation of my claim.

West Bend Mutual Insurance Company may re-disclose my records to others retained by West Bend Mutual Insurance Company to assist in the evaluation of my claim. Re disclosure of this protected health information will no longer be protected under the federal privacy rule.

The type of information to be disclosed may include, but is not limited to, x-rays, x-ray reports, summaries, reports, narratives, test results, notes and any other health care records from all in-patient and out-patient visits at your institution or facility.

This authorization also permits release of all information relating to treatment for:

- (a) drug and/or alcohol abuse;
- (b) any mental disease, defect, or psychological/psychiatric condition;
- (c) any communicable disease, AIDS, or AIDS-related disease.

I understand that executing this authorization is a waiver of my privilege of physician-patient confidentiality, and I freely and voluntarily waive that privilege.

The above-named health care provider may not condition treatment, payment, enrollment or eligibility of benefits on obtaining your authorization.

A photocopy or facsimile of this authorization shall be valid and effective just as the original.

I understand that I may revoke this authorization in writing to the records department of the above named health care provider at any time, except where information has already been released as a result of this authorization.

Unless revoked, this authorization shall remain in effect for the period of one year beyond the date of patient's signature, or until my claim is closed, whichever is later. Records may be disclosed whether dated before or after the date of this authorization.

I understand that I or my authorized representative is entitled to receive a copy of the completed authorization form.

Signature of Patient/Claimant

Date

Signature of Parent/Guardian/Representative

Date

ATTENTION

INDIANA EMPLOYERS HAVE THE RIGHT TO DIRECT MEDICAL TREATMENT FOR THEIR EMPLOYEES FOLLOWING A WORK RELATED INJURY OR ILLNESS

Indiana Worker's Compensation Statutes 22-3-3-4 and 22-3-3-6

To ensure your injured employees are receiving the best possible care following a work related injury or illness, we have attached a listing of medical providers available to treat your employee's occupational injuries and illnesses.

If you have had a positive experience with a medical provider that is not included on the attached listing, please advise your West Bend Mutual claim representative upon reporting the claim.

IMPORTANT

**For serious-life threatening injuries, please contact
9-1-1- accordingly.**

INDIANA MEDICAL PROVIDER LIST

Anderson

General - Ortho

Central Indiana Orthopedics

Dr. Nimu Surtani
2610 Enterprise Drive
Anderson, IN 46013
765-683-4400 (phone)
765-642-7903 (fax)

Bloomington

Ortho- Hand

Bloomington Bone & Joint Clinic

Dr. Dale Dellacqua
639 S. Walker Street, Suite E
Bloomington, IN 47403
812-333-4000
www.bbjsportmed.com

Ortho-Knee

Bloomington Bone & Joint Clinic

Dr. Greg Fox
639 S. Walker Street, Suite E
Bloomington, IN 47403
812-333-4000
www.bbjsportmed.com

Physiatrist

Rehabilitation Associates of Indiana

Dr. Paul Kern
717 S. Rogers Street
Bloomington, IN 47403
812-337-0700 (phone)

Crawfordsville

General - Ortho

Athens Orthopedic & Sports Med

Dr. Louis S. Metzman
1702 Lafayette Road
Crawfordsville, IN 47933
765-362-4400

Columbia City

Occupational Health

Parkview Occupational Health

885 W. Connexion Way
Columbia City, IN 46725
260-248-9260 (phone)
260-248-9279 (fax)

Crown Point

General - Ortho

Great Lakes Orthopedics

Dr. Keith Pitchford
1129 Merrillville Road
Crown Point, IN 46307
219-661-8661 (phone)

Great Lakes Orthopedics

Dr. David Dalsimer
1129 Merrillville Road
Crown Point, IN 46307
219-661-8661 (phone)

Danville

General - Ortho

OrthoIndy

Dr. Vincent Fragomeni
252 Meadow Drive
Danville, IN 46122
317-745-6443 (phone)
317-745-6451 (fax)

Ortho-Foot/Ankle

OrthoIndy

Dr. Michael P. Shea
252 Meadow Drive
Danville, IN 46122
317-745-6443 (phone)
317-745-6451 (fax)

Dunlap

Occupational Medicine

Methodist Occupational Health Center

2008 Lincolnway East
Goshen, IN 46526
574-537-9393 (phone)
574-537-9399 (fax)

East Chicago

Ortho-Hand

Dr. Ralph W. Richter, Jr.

4320 Fir Street, #303
East Chicago, IN 46312
219-392-1215 (phone)

INDIANA MEDICAL PROVIDER LIST

Elkhart

Ortho-Foot

OSMC

Dr. SJ Trumble
2310 California Road
Elkhart, IN 46514
574-264-0791 (phone)

General - Ortho

OSMC

Dr. C. W. Erekson
2310 California Road
Elkhart, IN 46514
574-264-0791 (phone)

Ortho-Hands

OSMC

Dr. Robert K. Ellis
2310 California Road
Elkhart, IN 46514
574-264-0791 (phone)

Back

OSMC

Dr. Mark A. Klaassen
2310 California Road
Elkhart, IN 46514
574-264-0791 (phone)

Elwood

General - Ortho

OrthoIndy

Dr. Timothy A. Hupfer
1331 South A Street
Elwood, IN 46036
765-552-4584 (phone)
317-802-2050 (fax)

Evansville

General - Ortho

Orthopedic Associates

Dr. James Goris
533 W. Columbia Street
Evansville, IN 47710
812-424-9291 (phone)

Tri State Orthopedics

Dr. Jenna Lee
520 Mary Street
Evansville, IN 47710
812-477-1558 (phone)

Ortho-Hand

Tri State Orthopedics

Dr. John Morgan
520 Mary Street
Evansville, IN 47710
812-477-1558 (phone)

Orthopedic Associates

Dr. Ross E. Marburger
533 W. Columbia Street
Evansville, IN 47710
812-424-9291 (phone)

General Surgery

Evansville Surgical Associates

Dr. Todd Burry
520 Mary Street, Suite 520
Evansville, IN 47710
812-424-8231 (phone)

Occupational Medicine

St. Mary's Occupational Medicine

Dr. James Butler
2330 Lynch Road
Evansville, IN 47711
812-485-6900 (phone)

Neurosurgeon

Tri State Neurosurgical Inc.

Dr. Mark Cobb
801 Saint Mary's Drive, Suite 400
Evansville, IN 47714
812-477-0900 (phone)

Tri State Neurosurgical Inc.

Dr. David J. Weaver
801 Saint Marys Drive, Evansville, IN
47714
812-477-0900 (phone)

Physiatrist

Tri-State Orthopedics

Dr. William Ante
225 Crosslake Drive
Evansville, IN 47715
812-477-1558 (phone)

Tri-State Orthopedics

Dr. Jeana J. Lee
225 Crosslake Drive
Evansville, IN 47715
812-477-1558 (phone)

Tri-State Orthopedics

Dr. Michael K. Mc Fadden
225 Crosslake Drive
Evansville, IN 47715
812-477-1558 (phone)

INDIANA MEDICAL PROVIDER LIST

Miscellaneous

Deaconess Comp Center
329 W. Columbia Street
Evansville, IN 47710
812-450-7455 (phone)

Fishers

Ortho-Hand/wrist/elbow

OrthoIndy
Dr. Timothy Dicke
10995 N. Allisonville Road
Suite 102
Fishers, IN 46038
317-915-8110 (phone)
317-915-8120 (fax)

General - Ortho

OrthoIndy
Dr. Timothy Hupfer
10995 N. Allisonville Road
Suite 102
Fishers, IN 46038
317-915-8110 (phone)
317-915-8120 (fax)

Fort Wayne

Hand – Ortho

Fort Wayne Orthopedics
Dr. Theodore Chaykowski
2514 E. Dupont Road
Fort Wayne, IN 46825
260-436-8686 (phone)

Orthopaedics Northeast
Dr. Ward Hamlet
5050 N. Clinton Street
Fort Wayne, IN 46825
260-484-8551 (phone)

Foot - Ortho

Orthopaedics Northeast
Dr. Tracy Pursley
5050 N. Clinton Street
Fort Wayne, IN 46825
260-484-8551 (phone)

Knee – Ortho

Knee & Shoulder Center, Inc.
Dr. William Rutledge
2510 E. Dupont Road, Suite 206
Fort Wayne, IN 46825
260-497-8855 (phone)

Fort Wayne Orthopedics
Dr. Jerald Cooper
7601 W. Jefferson Blvd.
Fort Wayne, IN 46804
260-436-8686 (phone)

Fort Wayne Orthopedics
Dr. Greg Sassmannshausen
2514 E. Dupont Road
Fort Wayne, IN 46825
260-436-8686 (phone)

Fort Wayne Orthopedics
Dr. Ronald G. Caldwell
2514 E. Dupont Road
Fort Wayne, IN 46825
260-436-8686 (phone)

Spine - Ortho

Fort Wayne Orthopedics
Dr. Alan McGee
2514 E. Dupont Road
Fort Wayne, IN 46825
260-436-8686 (phone)

Orthopaedics Northeast
Dr. Robert M. Shugart
5050 N. Clinton Street
Fort Wayne, IN 46825
260-484-8551 (phone)

Physiatrist

Fort Wayne Orthopedics
Dr. Mark Zolman
2514 E. Dupont Road
Fort Wayne, IN 46825
260-436-8686 (phone)

Fort Wayne Orthopedics
Dr. Thomas Lazoff
2514 E. Dupont Road
Fort Wayne, IN 46825
260-436-8686 (phone)

Fort Wayne Orthopedics
Dr. Dan Wilcox
2514 E. Dupont Road
Fort Wayne, IN 46825
260-436-8686 (phone)

Wayne Physical Medicine
Dr. Mark V. Reecer
5750 Coventry Lane, Suite 101
Fort Wayne, IN 46804
260-436-9337 (phone)

Trauma & Fractures (Mal Unions)

Fort Wayne Orthopedics
Dr. Matthew Hicks
2514 E. Dupont Road
Fort Wayne, IN 46825
260-436-8686 (phone)

Miscellaneous

Lutheran Health Network
7950 W. Jefferson Blvd.
Fort Wayne, IN 46804
260-435-7001 (phone)
www.luterhanhospital.com

INDIANA MEDICAL PROVIDER LIST

Parkview Occupational Health - Central

3103 E. State Blvd.
Fort Wayne, IN 46805
260-373-9300 (phone)
260-373-9301 (fax)

Parkview Occupational Health - South

9318 Airport Drive
Fort Wayne, IN 46809
260-373-9330 (phone)
260-373-9340 (fax)

Parkview Occupational Health – North

11115 Parkview Plaza Drive
Fort Wayne, IN 46845
260-672-4680 (phone)
260-672-4619 (fax)

Redi Med

5932 W. Jefferson Blvd.
Fort Wayne, IN 46804
260-436-2273 (phone)

Hobart

Spine

Spinal and Neurosurgical Institute

Dr. Wayel Kaakaji
1600 S. Lake Park Avenue, Suite 1102
Hobart, IN 46342
219-942-6510 (phone)

Huntington

Parkview Occupational Health

2855 North Park Avenue, Suite 102
Huntington, IN 46750
260-355-3570 (phone)
260-355-3836 (fax)

Redimed

1415 Flaxmil Road
Huntington, IN 46750
260-359-1250 (phone)

Indianapolis

Immediate Care Centers

Occupational Health Services

1709 N. Post Road
Indianapolis, IN

Occupational Medicine

Concentra Medical Center

5604 W. 74th Street
Indianapolis, IN 46278
317-290-1551 (phone)

Concentra Medical Center

6920 Gatwick Drive, Suite 100
Indianapolis, IN 46241
317-856-0740 (phone)

Integra Health Care

8150 Oaklandon Road
Indianapolis, IN 46236
317-823-8400 (phone)

Methodist Occupational Health Centers

1101 Southeastern Avenue
Indianapolis, IN 46202
317-955-2020 (phone)
317-955-2030 (fax)

5603 W. Raymond Street, Suite A

Indianapolis, IN 46202
317-241-8266 (phone)
317-247-4978 (fax)

1311 N. Shadeland Avenue

Indianapolis, IN 46219
317-352-0933 (phone)
317-357-8543 (fax)

7301 Georgetown Road, Suite 109

Indianapolis, IN 46268
317-875-9584 (phone)
317-872-2850 (fax)

6349 South East Street

Indianapolis, IN 46227
317-780-0123 (phone)
317-780-0119 (fax)

9800 Westpoint Drive

Indianapolis, IN 46256
317-585-5050 (phone)
317-585-5040 (fax)

St. Vincent Occupational Health

5460 Lafayette Road
Indianapolis, IN 46254
317-415-7337 (phone)

Community Occupation Health

8177 Clearvista Pkwy
Indianapolis, IN 46256
317-621-7808 (phone)

Ortho-Hand

Indiana Hand Center

Dr. Robert Baltera
8501 Harcourt Road
Indianapolis, IN 46260
317-875-9105 (phone)
317-875-8638 (fax)

Indiana Hand Center

Dr. James J. Creighton, Jr.
8501 Harcourt Road
Indianapolis, IN 46260
317-875-9105 (phone)
317-875-8638 (fax)

INDIANA MEDICAL PROVIDER LIST

Indiana Hand Center

Dr. Jeffrey A. Greenberg
8501 Harcourt Road
Indianapolis, IN 46260
317-875-9105 (phone)
317-875-8638 (fax)

OrthoIndy

Dr. Timothy Dicke
8450 Northwest Blvd.
Indianapolis, IN 46278
317-802-2000 (phone)
317-802-2050 (fax)

Dr. Dion D. Chavis

8051 South Emerson Avenue
Suite 360 A
Indianapolis, IN 46237
317-859-1120 (phone)
317-859-1525 (fax)

Foot – Ortho

OrthoIndy

Michael Shea
1801 N. Senate Blvd., Suite 200
Indianapolis, IN 46202
317-802-2000 (phone)
317-924-0115 (fax)

OrthoIndy

Daniel Lehman
8450 Northwest Blvd.
Indianapolis, IN 46278
317-802-2000 (phone)

General - Ortho

Methodist Sports Medicine

Dr. Peter Sallay
201 Pennsylvania Parkway, Suite 200
Indianapolis, IN 46280
317-817-1200 (phone)

Methodist Sports Medicine

Dr. Gary Misamore
201 Pennsylvania Parkway, Suite 200
Indianapolis, IN 46280
317-817-1200 (phone)

OrthoIndy

Dr. Timothy A. Hupfer
8450 Northwest Blvd.
Indianapolis, IN 46278
317-802-2000 (phone)
317-802-2050 (fax)

OrthoIndy

Dr. Bradley A. Jelen
8450 Northwest Blvd.
Indianapolis, IN 46278
317-802-2000 (phone)
317-802-2050 (fax)

OrthoIndy

Dr. David Brokaw
1801 N. Senate Blvd., Suite 200
Indianapolis, IN 46202
317-917-4396 (phone)
317-924-0115 (fax)

Ortho-Shoulders

OrthoIndy

Dr. Scott Gudeman
5255 E. Stop 11 Road, Suite 300
Indianapolis, IN 46237
317-884-5200 (phone)
317-884-5360 (fax)

OrthoIndy

Dr. Stephen Kollias
8450 Northwest Blvd.
Indianapolis, IN 46278
317-802-3232 (phone)
317-802-2050 (fax)

OrthoIndy

Dr. Jeffery Soldatis
10601 N. Meridian Street, Suite 200
Indianapolis, IN 46290
317-575-2700 (phone)

Physiatrist

Integra Health Center

Dr. Scott Taylor
8150 Oaklandon Road
Geist Station, Suite 111
Indianapolis, IN 46236
317-823-8400 (phone)
317-823-8402 (fax)

Integra Health Center

Dr. Jeff Thomas
8150 Oaklandon Road
Geist Station, Suite 111
Indianapolis, IN 46236
317-823-8400 (phone)
317-823-8402 (fax)

Indiana University Medical Center

Dr. Ralph Buschbacher
541 Clinical Drive, Suite 368
Indianapolis, IN 46202-5233
317-278-0200 (phone)

OrthoIndy

Dr. John R. McLimore
8450 Northwest Boulevard
Indianapolis, IN 46278
317-802-3233 (phone)
317-802-2050 (fax)

OrthoIndy

Dr. David Steinberg
5255 E. Stop 11 Road, Suite 300
Indianapolis, IN 46237
317-884-5200 (phone)
317-884-5360 (fax)

INDIANA MEDICAL PROVIDER LIST

Spine

OrthoIndy

Dr. John Dietz
8450 Northwest Blvd.
Indianapolis, IN 46278
317-802-2000 (phone)
317-802-2050 (fax)

OrthoIndy

Dr. Robert Huler
1801 N. Senate Blvd., Suite 200
Indianapolis, IN 46202
317-917-4394 (phone)

OrthoIndy

Dr. Joseph Riina
5255 E. Stop 11 Road, Suite 300
Indianapolis, IN 46237
317-884-5358 (phone)
317-884-5360 (fax)

OrthoIndy

Dr. David Schwartz
1801 N. Senate Blvd., Suite 200
Indianapolis, IN 46202
317-917-4392 (phone)
317-924-0115 (fax)

Trauma & Fractures (Mal Unions)

OrthoIndy

Dr. Timothy Weber
1801 N. Senate Blvd., Suite 200
Indianapolis, IN 46202
317-917-4392 (phone)
317-924-0115 (fax)

OrthoIndy

Dr. Kevin Scheid
1801 N. Senate Blvd., Suite 200
Indianapolis, IN 46202
317-917-4392 (phone)
317-924-0115 (fax)

Neurologists

IN University Neurology

Dr. James Fesenmeier
1115 Ronald Regan Pkwy #141
Avon, IN 46123
317-278-3200 (phone)

Josephson Wallack Munshower

Dr. Kristi George
7250 Clearvista Drive, Suite 225
Indianapolis, IN 46256
317-621-2288 (phone)

Neurology Associates Inc.

Dr. Kevin Puzio
1400 N. Ritter Ave., Suite 451
Indianapolis, IN 46219
317-570-6378 (phone)

Indiana Spine Group

Dr. Kenneth Renkens
8402 Harcourt Road, Suite 400
Indianapolis, IN 46260
317-228-7000 (phone)

Psychology

Dr. Gregory Hale PhD

10291 N. Meridian St., Suite 180
Indianapolis, IN 46290
317-844-5628 (phone)

Kendallville

Occupational Health

Parkview Occupational Health

1844 Ida Red Road
Kendallville, IN 46755
260-347-8810 (phone)
260-347-8933 (fax)

Kokomo

Ortho-Hand

Dr. Andrew Mandery

615 St. Joseph Drive
Kokomo, IN 46901
765-236-1290 (phone)

Lafayette

Occupational Medicine

Unity Healthcare

Dr. Joseph Sliwkowski
1345 Unity Place
Lafayette, IN 47905
765-447-8133 (phone)

Shoulder

Arnett Clinic

Dr. Jeffrey McIntosh
1500 Salem St.
Lafayette, IN 47904
765-448-8000 (phone)

LaGrange

Occupational Medicine

LaGrange Occupational Health

207 N. Town Line Road
LaGrange, IN 46761
260-463-2143 (phone)

Parkview Occupational Health

207 N. Townline Road
LaGrange, IN 46761
260-463-2143, ext. 6633 (phone)
260-463-2459 (fax)

INDIANA MEDICAL PROVIDER LIST

LaPorte

Occupational Medicine

LaPorte Health Center
311 Boyd Blvd.
LaPorte, IN 46350
219-326-2654 (phone)
219-326-2653 (fax)

Merrillville

Ortho-Hand

Orthopedic Centers
Dr. Brian Coleman
333 W. 89th Avenue, Suite W1
Merrillville, IN 46410
219-763-3935 (phone)

Michigan City

Occupational Medicine

LaPorte Health Center
220 Dunes Plaza Hwy 421 & 20
Michigan City, IN 46360
219-878-8832 (phone)
219-874-4476 (fax)

Mishawaka

General - Ortho

Institute for Orthopedic & Nerve Surgery
Dr. Thomas Akre
230 E. Day Road, Suite 130
Mishawaka, IN 46545
574-247-4667 (phone)

Munster

Spine

Orthopedic Specialist-NW
Dr. Dwight Tyndall
730 45th Avenue
Munster, IN 46321
219-924-3300 (phone)
New Albany

General - Ortho

Dr. Edward Bell
1919 State Street, Suite 462
New Albany, IN 47150
812-945-8792 (phone)

New Castle

General - Ortho

Orthopedic Surgery & Sports
Dr. Lindsey R. Rolston
2200 Forest Ridge Pkwy., #240
New Castle, IN 47392
765-521-7385 (phone)

Physiatrist

Orthopedic Surgery & Sports
Dr. Scott Taylor
2200 Forest Ridge Pkwy., #240
New Castle, IN 47392
765-521-7385 (phone)

South Bend

Spine - Ortho

South Bend Orthopaedic Surgery
Dr. Jamie Gottlieb
53880 Carmichael Drive
South Bend, IN 46635
574-247-9441 (phone)

Knees - Ortho

South Bend Orthopaedic Surgery
Dr. Michael A. Yergler
53880 Carmichael Drive
South Bend, IN 46635
574-247-9441 (phone)

Occupational Medicine

Memorial Center-Occupational
2301 N. Bendix Drive
South Bend, IN 46628
574-647-1675 (phone)

Hands/Elbows-

OrthoSouth Bend Orthopaedic Surgery
Dr. Adelbert J. Mencias
53880 Carmichael Drive
South Bend, IN 46635
574-247-9441 (phone)

INDIANA MEDICAL PROVIDER LIST

Terre Haute

Ambucare Clinic

3387 US Highway 41
Terre Haute, IN 47802
812-232-5532 (phone)

Occupational Medicine

Center of Occupational Health – Union Hospital

4001 Wabash Avenue
Terre Haute, IN 47803
812-238-7788 (phone)
812-478-4178 (fax)

Center of Occupational Health – Union Hospital

5500 South US Highway 41
Terre Haute, IN 47802

Valparaiso

Spine – Ortho

Valparaiso Orthopedic Clinic

Dr. Thomas H. Kay
2501 Cumberland Drive
Valparaiso, IN 46383
219-464-8581 (phone)

Vincennes

General - Ortho

Quest Orthopedics

Dr. Terry Fenwick
702 Old Wheatland Road
Vincennes, IN 47591
812-882-6637 (phone)

JOB ANALYSIS

Name			Claim Number				
Employer			Address				
Date of Hire	Date of Injury	Job Title			Check One <input type="checkbox"/> Skilled <input type="checkbox"/> Unskilled		
Training Required to Learn Job							
Was Employee Working as a Supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Number of People Supervised		Employee Worked: <input type="checkbox"/> Alone <input type="checkbox"/> Small Group (3-5) <input type="checkbox"/> Large Group			
Days Worked Per Week (Circle) M Tu W Th F Sat Sun		Hours Worked During Week From _____ To _____			Shift _____		
Work Breaks (Daily Rest Periods and Lunch)							
Morning —		Lunch —		Afternoon —			
Minutes		Minutes		Minutes			
Overtime Per Week Number of Hours		How Often		Was Employee Hired With Any Restrictions? (Check) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, Specify							
Body Movements – Amount Spent Each Day							
Sitting		Standing		Walking			
%		%		%			
Check Appropriate Column				None	Occasion-ally (1/3 or Less)	Frequently (1/3 – 2/3)	Continuously (2/3 or more)
Reaching above shoulder length							
Working with body bent over at waist							
Working in kneeling position							
Crawling							
Bending, stooping, squatting							
Repetitive foot movements as in foot controls – L/R or both							
Climbing stairs							
Climbing Ladders							
Working with arms extended at shoulder level							
Working with arms above shoulder height							
Height from floor of object to be reached and/or worked on (use space for drawing, if needed):							
Object		Height					
Weights Handled	Item	Alone or Assisted	Push, Pull Or Lift	Times Per Hour	Times Per Day	Times Per Week	Times Per Month
1 – 10 lbs.							
15 – 20 lbs.							
25 – 35 lbs.							
45 – 60 lbs.							
65 – 80 lbs.							
85 – 100 lbs.							
<input type="checkbox"/> No lifting required for this job.							

Hand Coordination Activities (Check Appropriate Column)					
Movement Required	Tool/Machine		Right	Left	Both
Major hand					
Fine Manipulation					
Gross Manipulation					
Simple Grasping					
Power Grip					
Hand Twisting					
Pushing					
Pulling					
Tools Used By Worker		Weight	No. of Hands Needed To Move		
Objects Worker Must Move During Day		Weight	Distance	No. of Workers Needed To Move	
Physical Surroundings Does Employee Work <input type="checkbox"/> Inside ___% <input type="checkbox"/> Outside ___%		Does Employee Walk On Uneven Ground? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does Employee Work Around Moving Machinery? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does Employee Drive Automotive Equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, describe:					
Does the Employee Come In Contact With The Following? (Indicate Type)	Yes	No	Type		
Fumes					
Dust					
Mist					
Steam					
Strong Odors					
Poor Ventilation					
Air Conditioning					
Characteristics Of Job That Cannot Be Modified By Employer For This Employee					
Comments And/Or Observations					
<input type="checkbox"/> Job Site Evaluation Done			<input type="checkbox"/> Narrative Discussion Only		
Name(s) of Person(s) Interviewed			Title		
Person Completing Analysis		Title		Date	

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Claim No. _____

Patient's Name (First)

(Middle Initial)

(Last)

Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK

Diagnosis/Condition (Brief Explanation)

I saw and treated this patient on _____ and based on the above description of the patient's current medical problem:
(date)

1. Recommend his/her return to work with no limitations on _____
(date)

2. He/She may return to work on _____ capable of performing the degree of work checked below with the following limitations: (date)

- Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
- Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.
- Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.
- Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.
- Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.
- Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8 hour work day patient may:
 - a. Stand/Walk
 None 1-4 hours 4-6 hours 6-8 hours
 - b. Sit
 1-3 hours 3-5 hours 5-8 hours
 - c. Drive
 1-3 hours 3-5 hours 5-8 hours
2. Patient may use hand(s) for repetitive:
 - Single Grasping
 - Pushing & Pulling
 - Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:
 - Yes No
4. Patient is able to:

	Frequently	Occasionally	Not At All
a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ or until patient is re-evaluated on _____
(date) (date)

3. He/She is totally incapacitated at this time. Patient will be re-evaluated on _____
(date)

Physician's Signature

Date

RETURN TO WORK LOG

EMPLOYEE NAME _____ SUPERVISOR _____

Date	Hours Worked		Tasks Performed	Comments Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I clearly understand, take responsibility for, and acknowledge the limitations my physician, Dr. _____ has placed on me while participating in this temporary transitional work program.

Employee Signature

Date

RETURN TO WORK LOG INFORMATION

The Return To Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps eliminate potential conflicts should the question arise regarding the employee performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employee's restrictions to the log.
- Have employee write name on top of log and the Supervisor write their name.
- Remind employee it is their responsibility to follow the restrictions.
- Remind employee that the restrictions apply to occupational AND non-occupational activities.
- Employee and supervisor review all tasks completed each day, indicate any concerns and everyone signs the form.