

Completion Instructions:

- **Supervisor:** Complete the client company section.
- **Employee:** Have medical provider complete the last section and then submit the form to your supervisor *immediately after doctor visit.*

To Be Completed by Client Company				
Employee Name	Last Four Digits of Social Security No.	Insperty Employee ID No. <div style="border: 1px solid black; padding: 2px; display: inline-block;">OR</div>		
Job Title	Client Company Name			
<p>The above named Insperty employee requires initial treatment for an injury that occurred on _____ (date). Payment will be made for reasonable and necessary medical treatment related to a compensable work-related injury.</p> <p>All post-accident drug/alcohol screening must be approved by Insperty. When drug/alcohol screening is approved, please follow protocols in place that specify the appropriate procedures to follow. Bill the cost of the testing to the Workers' Compensation claims carrier.</p> <p>Modified duty work available at client location: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>				
<p>Employer: Insperty 19001 Crescent Springs Drive Kingwood, TX 77339-3802 800-242-8893, ext. 4244 Fax: 800-430-4738</p>	<p style="text-align: center;">Billing Information:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px; text-align: center;"> <i>For Texas, California, Florida and New Jersey:</i> Post Office Box 14214 Lexington, KY 40512 Fax: 859-264-4383 </td> <td style="width: 50%; padding: 5px; text-align: center;"> <i>For All Other States:</i> Post Office Box 14205 Lexington, KY 40512 Fax: 859-264-4383 </td> </tr> </table>		<i>For Texas, California, Florida and New Jersey:</i> Post Office Box 14214 Lexington, KY 40512 Fax: 859-264-4383	<i>For All Other States:</i> Post Office Box 14205 Lexington, KY 40512 Fax: 859-264-4383
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Onsite Supervisor/Representative Signature	Printed Name	Date		

To Be Completed by Medical Provider		
Health Care Provider	Date	
Type Of Injury	Body Part Injured	
<input type="checkbox"/> Full duty release as of _____ (date) <input type="checkbox"/> Restrictions (as noted below) in effect for _____ days Follow up appointment on: _____ with _____		
<p>GENERAL RESTRICTIONS: <i>Please check all that apply.</i></p> <p><input type="checkbox"/> 1. No repetitive grasping</p> <p><input type="checkbox"/> 2. No repetitive fine manipulation</p> <p><input type="checkbox"/> 3. No repetitive pushing/pulling</p> <p><input type="checkbox"/> 4. No repetitive squatting/kneeling</p> <p><input type="checkbox"/> 5. No climbing stairs or ladders</p> <p><input type="checkbox"/> 6. No twisting</p> <p><input type="checkbox"/> 7. No reaching above shoulders</p> <p><input type="checkbox"/> 8. Must keep wound clean & dry</p> <p><input type="checkbox"/> 9. Must wear brace/sling</p> <p><input type="checkbox"/> 10. Unable to drive company vehicle</p> <p><input type="checkbox"/> 11. Must wear eye patch</p> <p><input type="checkbox"/> 12. No repetitive use - upper</p>	<p>LIFTING/STANDING/BENDING:</p> <p>No repetitive lifting over:</p> <p><input type="checkbox"/> 0-5 lbs. <input type="checkbox"/> 5-10 lbs. <input type="checkbox"/> 10 lbs. <input type="checkbox"/> 20 lbs.</p> <p>No prolonged standing/walking longer than _____ hours</p> <p><input type="checkbox"/> 1 hr <input type="checkbox"/> 1-4 hrs. <input type="checkbox"/> 4-6 hrs. <input type="checkbox"/> 6-8 hrs.</p> <p>No bending greater than _____ times per hour</p> <p><input type="checkbox"/> 10X <input type="checkbox"/> 20X <input type="checkbox"/> 30X <input type="checkbox"/> 40X</p>	<p>PUSHING/PULLING/SITTING:</p> <p>No pushing/pulling over _____ lbs:</p> <p><input type="checkbox"/> 0-5 lbs. <input type="checkbox"/> 5-10 lbs. <input type="checkbox"/> 10 lbs. <input type="checkbox"/> 20 lbs.</p> <p>Should be sitting _____% of the time:</p> <p><input type="checkbox"/> 1 hr <input type="checkbox"/> 1-4 hrs <input type="checkbox"/> 4-6 hrs. <input type="checkbox"/> 6-8 hrs.</p> <p>Must use crutches _____ % of the time:</p> <p><input type="checkbox"/> 1 hr. <input type="checkbox"/> 2 hrs. <input type="checkbox"/> 3 hrs. <input type="checkbox"/> 4 hrs.</p>
Doctor's Signature	Printed Name	Date