Q3 *Business Technology Corp.*
P. O. Box 15952
Fort Wayne, IN 46885

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Phone 260.492.9979 877.251.8324
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Group Disability Release To Work Form

Please print in ink or type – Return this form to Q3 using contact info above.
Note: Every item must be completed before claim can be processed!

Employee Section

Employee Name: _____ DOB: _____

Physician Section

A. ❑ The employee is able to work a full, regular schedule with no restrictions, beginning _____.

B. ❑ The employee is able to return to work on a reduced schedule required by this condition beginning _____ through _____ with a full release on _____.

Reduced schedule maximum weekly work hours _____

Reduced schedule maximum daily work hours _____

C. ❑ The employee is able to return to work with restrictions required by this condition beginning _____ through _____.

Limitation in the number of hours worked:

Work no more than ____ hours/day Work no more than ____ hours/week

During Work Hours:

Stand no more than ____ hours Walk no more than ____ hours

Sit no more than ____ hours

Frequently = 34%-66% of the time - Occasionally = 1%-33% of the time

❑ Lift up to ____ pounds ❑ Frequently or ❑ Occasionally

❑ Push/pull/force up to ____ pounds ❑ Frequently or ❑ Occasionally

❑ Bend, twist, stoop ❑ Frequently or ❑ Occasionally

❑ Reaching ❑ Frequently or ❑ Occasionally

Additional Major Life Activities:

❑ Concentration ❑ Think ❑ Hear ❑ Learn ❑ Performing Manual Tasks ❑ Caring for Oneself
❑ Interact with others ❑ Sleep ❑ Eat ❑ Read ❑ Communication ❑ Other _____
❑ Work ❑ Sight ❑ Breath ❑ Speak ❑ Major Bodily Functions (Please List) _____

Explain: _____

_____ _____ _____
Signature of Attending Physician Degree Date

_____ _____
Name of Attending Physician Telephone Number

_____
Office Name of Attending Physician

_____ _____
Street Address City, State, Zip Code