

**PHYSICIAN'S FORM  
INSTRUCTIONS/DEFINITIONS**

**The use of this form is required by the Delaware Workers' Compensation Statute, 19 Del.C. §2322E, to report all information specific to this workers' compensation injury.**

***Complete all applicable fields. Your office notes and records do not replace this form.***

1. **Report Type:** Check "Initial" if this is the first visit related to this described injury. Check "Progress" when there has been any material change in the injured employee's physical capability which impacts the employee's return to work status. Check "Closing" if: injured worker is discharged from care.
2. **Case Information:**
  - ◆ **Injured Worker's Name:** Name of the injured worker.
  - ◆ **Date of Birth:** The injured worker's date of birth.
  - ◆ **Date of Injury:** Date of this injury.
  - ◆ **Exam Date:** Date of office visit if applicable.
  - ◆ **Physician's Phone/Fax:** The telephone and fax numbers of the physician completing this form.
  - ◆ **Employer Name:** The name of the employer associated with the claim.
  - ◆ **Employer Phone/Fax:** The telephone and fax numbers of the employer.
  - ◆ **Insurer Name:** The name of the insurance carrier associated with the claim, if known.
  - ◆ **Insurer Claim #:** The claim number assigned by the insurance carrier or self-insured employer, if known.
  - ◆ **Insurer Phone/Fax:** The telephone and fax numbers of the insurance carrier associated with the claim, if known.
3. **Initial Visit:** Relate in injured worker's words description of accident/injury.
4. **Work Related Medical Diagnosis(es):** State the injured worker's work related medical diagnosis(es).
5. **Treatment Plan:** Complete all applicable portions regarding treatment. Indicate frequency and duration.
  - ◆ **Diagnostic tools/tests:** EMG, MRI, CT-scan, etc.
  - ◆ **Procedures:** Any medical procedure including surgical procedures, castings, etc.
  - ◆ **Therapy:** Physical therapy, occupational therapy, home exercise, etc., including plan specifications.
  - ◆ **Medications:** Antibiotics, analgesics, anti-inflammatory drugs, etc.
  - ◆ **Other:** Any treatment not covered above
6. **Hours Per Day Patient Can Work:** Circle the number of hours applicable to this patient.
7. **D.O.T. Classification of Work:** Circle the classification of work applicable to this patient.
8. **Work Postures/Positional Tolerances:** Comment as appropriate in the space provided regarding the patient's abilities/limitations for the postures/positions listed.
9. **Comments:** To be used to explain/clarify any information required by this form.
10. **Restrictions:** Check applicable category.
11. **Return to Work:** Provide regular duty/modified duty start date.
12. **Reevaluation Date:** Provide date of next evaluation.
13. **Physician Information:** Type or print the name of the physician and circle "yes" or "no" as to whether the physician is a Certified Provider. The health care provider most responsible for the treatment of the employee's work-related injury must sign and date the report.

**EVERY HEALTH CARE PROVIDER WHO EVALUATES OR TREATS AN EMPLOYEE SHALL COMPLETE AND SUBMIT, AS EXPEDITIOUSLY AS POSSIBLE AND NOT LATER THAN 10 DAYS AFTER THE DATE OF FIRST EVALUATION OR TREATMENT, A REPORT OF EMPLOYEE CONDITION AND LIMITATIONS, ON A FORM ADOPTED FOR THAT PURPOSE PURSUANT TO THIS SECTION, AND SHALL EXPEDITIOUSLY PROVIDE COPIES OF THE REPORT OF EMPLOYEE CONDITION AND LIMITATIONS TO THE EMPLOYEE, THE EMPLOYER AND THE EMPLOYER'S INSURANCE CARRIER, IF APPLICABLE, AS REQUIRED BY 19 DEL.C. §2322E(b)**

DELAWARE WORKERS' COMPENSATION  
PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY  
**A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER, EMPLOYER AND THE INSURER**

REPORT TYPE                     X  Initial                    \_\_\_ Progress                    \_\_\_ Closing

WORKER'S NAME  John Doe   
DOB                     01/25/78   
Date of Injury         12/02/08   
EXAM DATE            12/05/08   
Physician's Phone/Fax  302-555-4444   
Employer Name         XYZ Manufacturing   
Employer Phone/Fax  302-555-5555 / 302-555-5566   
Insurer Name         ABC ED Insurance   
Insurer Claim No.    1a2c3y3b3g   
Insurer Phone/Fax    302-555-4545 / 302-555-5454

INITIAL VISIT ONLY  
Injured worker's description of accident/injury  Injured back lifting a box from the floor

WORK RELATED MEDICAL DIAGNOSIS (ES)  Lumbosacral Strain

TREATMENT PLAN:  
Diagnostic Tests  X-rays   
Procedures  None   
Therapy  Physical Therapy 3x / week for 4 weeks   
Medications  Naprosyn, Flexiril

Hrs. per day patient can work: (circle one)     8     6    4    2    0

**D.O.T. Classification of Work** (Circle one)

- Sedentary    Exerting up to 10 lbs. of force *occasionally* and/or a negligible amount of force *frequently* to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.
- Light        Exerting up to 20 lbs. of force *occasionally* and/or up to 10 lbs. of force *frequently* and/or negligible amount of force *constantly* to move objects. Physical demand requirements are in excess of those for Sedentary Work.
- Medium      Exerting 20 to 50 lbs. of force *occasionally* and/or 10 to 25 lbs. of force *frequently* and or greater than negligible up to 10 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Light Work.
- Heavy        Exerting 50 to 100 lbs. of force *occasionally* and/or 25 to 50 lbs. of force *frequently* and/or 10 to 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Medium Work.
- Very Heavy   Exerting in excess of 100 lbs. of force *occasionally* and/or in excess of 50 lbs. of force *frequently* and/or in excess of 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Heavy Work.

**Definitions:**  
**Occasionally:** activity or condition exists up to 1/3 of the time  
**Frequently:** activity or condition exists from 1/3 to 2/3 of the time  
**Constantly:** activity or condition exists 2/3 or more of the time

**Work Postures/Positional tolerances:** Comment **as appropriate** in the space provided regarding the patient's abilities/limitations for the following

Postures/Positions. (e.g. Sitting: No more than 30 minutes continuously)

Sitting: <u> Limit to 30 minutes continuously </u>	Squatting: <u> Safe without weight </u>
Standing: _____	Crawling: _____
Walking: _____	Climbing: _____
Driving: _____	Repeated arm motions: _____
Bending: <u> No bending at waist </u>	Repetitive use of wrist/hands: _____
Turn/Twist: <u> Limit to 1-2x / hour </u>	Reaching up above shoulder: _____
Kneeling: _____	Foot controls: _____

Comments: \_\_\_\_\_  
\_\_\_\_\_

Above safe work capacities are:    temporary  X     permanent \_\_\_\_\_    anticipate full duty release \_\_\_\_\_  
Return to work modified duty start date:  Immediately

RELEASE TO FULL DUTY WITH NO RESTRICTIONS (Please Circle)    YES (Start date \_\_\_\_\_)    NO

Physician Signature:  James Physician                     Date:  12/05/08

Physician Name: (Please print)  James Physician, M.D.                     Certified Provider:  YES  NO

**EMPLOYER'S FORM  
INSTRUCTIONS/DEFINITIONS**

**The use of this form is required by the Delaware Workers' Compensation Statute, 19 Del.C. §2322E, to report all information specific to this workers' compensation injury.**

*Complete all applicable fields.*

**1. Case Information:**

- ◆ **Employer Name:** The name of the employer associated with the claim.
- ◆ **Employee Name:** Name of the injured worker.
- ◆ **Modification Duty Information:** Complete all applicable fields
- ◆ **Employer Fax:** The telephone and fax numbers of the employer.
- ◆ **Job Title:** Provide job title for position available.
- ◆ **Job Description:** Provide description of physical requirements of job duties for position available.
- ◆ **Environment/Working Conditions:** Identify any environmental factors relevant to position available.

**2. Hours Per Day Job Available:** Circle the number of hours applicable.

**3. Additional Information:** Circle the applicable work status categories for the position available, and comment as appropriate in the space provided regarding the work postures/positional requirements for the modified duty job available.

**4. Employer:** Provide job availability date.

**5. Comments:** To be used to explain/clarify any information required by this form.

**6. Employer Information:** The person responsible for completing this form on behalf of the employer must sign and date this form.

**WITHIN FOURTEEN (14) DAYS OF RECEIVING A NOTICE OF INJURY, THE EMPLOYER SHALL PROVIDE THIS FORM TO THE INJURED WORKER'S HEALTH CARE PROVIDER/PHYSICIAN AND THE EMPLOYER'S INSURANCE CARRIER AS REQUIRED BY 19 DEL.C. §2322E(d).**

**THE HEALTH CARE PROVIDER/PHYSICIAN MUST COMPLETE HIS/HER PORTION OF THIS FORM AND SIGN AND RETURN IT TO THE EMPLOYER WITHIN FOURTEEN (14) DAYS OF THE NEXT DATE OF SERVICE AFTER THE PHYSICIAN'S RECEIPT OF THE FORM FROM THE EMPLOYER, BUT NOT LATER THAN TWENTY-ONE (21) DAYS FROM THE PHYSICIAN'S RECEIPT OF SUCH FORM.**

DELAWARE WORKERS' COMPENSATION  
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

DATE: 12/3/09

EMPLOYER: XYZ Manufacturing EMPLOYEE: John Doe

IS MODIFIED DUTY AVAILABLE:  Yes  No EMPLOYER FAX #: 302-999-9999

IF AVAILABLE, FOR WHAT PERIOD OF TIME: 6 Weeks  Indefinite

JOB TITLE: Packer

JOB DESCRIPTION: Pack boxes onto pallets

ENVIRONMENT/WORKING CONDITIONS (e.g., Temperature): Indoor, no temp extremes, moderate noise

Hrs. per day job available: (circle minimum and maximum) (8) 6 4 (2) 0

**D.O.T. Classification of Work** (Circle one)

- Sedentary Exerting up to 10 lbs. of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.
- (Light) Exerting up to 20 lbs. of force occasionally and/or up to 10 lbs. of force frequently and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work.
- Medium Exerting 20 to 50 lbs. of force occasionally and/or 10 to 25 lbs. of force frequently and or greater than negligible up to 10 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.
- Heavy Exerting 50 to 100 lbs. of force occasionally and/or 25 to 50 lbs. of force frequently and/or 10 to 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.
- Very Heavy Exerting in excess of 100 lbs. of force occasionally and/or in excess of 50 lbs. of force frequently and/or in excess of 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.

**Definitions:**

- Occasionally:** activity or condition exists up to 1/3 of the time  
**Frequently:** activity or condition exists from 1/3 to 2/3 of the time  
**Constantly:** activity or condition exists 2/3 or more of the time

**Work Postures/Positional requirements:** Comment as appropriate in the space provided regarding the following Postures/Positions for the modified duty job available.

Sitting: requires 1-2 hrs / day Squatting: Occasionally Standing: Constantly  
Crawling: \_\_\_\_\_ Walking: Frequently Climbing: \_\_\_\_\_  
Driving: \_\_\_\_\_ Repeated arm motions: \_\_\_\_\_ Bending: \_\_\_\_\_  
Turn/Twist: Occasionally Kneeling: \_\_\_\_\_ Foot controls: \_\_\_\_\_  
Reaching up above shoulder: \_\_\_\_\_ Repetitive use of wrist/hands: \_\_\_\_\_

Comments: Sitting can be broken up into 30 minute intervals

EMPLOYER: Date job is available: Immediately

Comments: \_\_\_\_\_

Employer Signature: [Signature] Date: 12/03/09

PHYSICIAN: I approve the job described above. (X) Yes. ( ) No.  
If no, reasons for disapproval/recommended modifications: \_\_\_\_\_

Physician Signature: [Signature] Date: 12/22/08

Physician Name (Please print) James Physician, M.D. Certified provider: (YES) NO

**The Health Care Provider/Physician MUST complete his/her portion of this form and SIGN and RETURN it to the EMPLOYER within fourteen (14) days of the next date of service after the HC Provider/Physician's receipt of the form from the employer, but not later than twenty-one (21) days from the HC Provider/Physician's receipt off such form.**