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.

The health care provider most responsible for the treatment of the employee's work-related injury 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 ___ Initial ___Progress ___Closing

WORKER'S NAME_____

DOB _____
Date of Injury _____
EXAM DATE _____
Physician's Phone/Fax_____

Employer Name _____
Employer Phone/Fax _____
Insurer Name _____
Insurer Claim No. _____
Insurer Phone/Fax _____

INITIAL VISIT ONLY
Injured worker's description of accident/injury_____

_____

WORK RELATED MEDICAL DIAGNOSIS (ES) _____

_____

TREATMENT PLAN:
Diagnostic Tests_____
Procedures_____
Therapy_____
Medications_____

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: _____ Squatting: _____
Standing: _____ Crawling: _____
Walking: _____ Climbing: _____
Driving: _____ Repeated arm motions: _____
Bending: _____ Repetitive use of wrist/hands: _____
Turn/Twist: _____ Reaching up above shoulder: _____
Kneeling: _____ Foot controls: _____

Comments:_____

_____

_____

Above safe work capacities are: temporary _____ permanent _____ anticipate full duty release _____

Return to work modified duty start date: _____

RELEASE TO FULL DUTY WITH NO RESTRICTIONS (Please Circle) YES (Start date_____) NO

Physician Signature: _____ Date: _____

Physician Name: (Please print) _____ Certified Provider:: YES NO