

DELAWARE WORKERS' COMPENSATION
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

DATE: _____

EMPLOYER: _____ EMPLOYEE: _____

IS MODIFIED DUTY AVAILABLE: ____ Yes ____ No EMPLOYER FAX #: _____

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

JOB TITLE: _____

JOB DESCRIPTION: _____

ENVIRONMENT/WORKING CONDITIONS (e.g., Temperature): _____

ADDITIONAL INFORMATION:

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

Work Postures: Maximum required hours for above work day (circle one in each category below):

Sitting: 0 1 2 3 4 5 6 7 8

Standing: 0 1 2 3 4 5 6 7 8

Walking: 0 1 2 3 4 5 6 7 8

Driving: 0 1 2 3 4 5 6 7 8

Comments: _____

Lift/Carry & Push/Pull:

D.O.T. Classification of Work

Lift/Carry
check one:

Push/Pull
check one:

Sedentary	10 lbs max: occasionally carry small objects	()	()
Light	up to 20 lbs max: frequently lift/carry up to 10 lbs	()	()
Medium	up to 50 lbs max. frequently lift/carry up to 25 lbs	()	()
Heavy	up to 100 lbs max. frequently lift/carry up to 50 lbs	()	()
Very Heavy	over 100 lbs occasionally; frequently lift/carry over 50 lbs	()	()

Based on the total hrs. per day job is available, this job requires (circle one in each category below):

Bending:	0%	25%	50%	75%	100%
Turn/Twist:	0%	25%	50%	75%	100%
Kneeling:	0%	25%	50%	75%	100%
Squatting:	0%	25%	50%	75%	100%
Crawling,	0%	25%	50%	75%	100%
Climbing:	0%	25%	50%	75%	100%
Repeated arm motions:	0%	25%	50%	75%	100%
Reaching up above shoulder:	0%	25%	50%	75%	100%
Foot controls:	0%	25%	50%	75%	100%

EMPLOYER: Date job is available: _____

Comments: _____

Employer Signature: _____ Date: _____

PHYSICIAN: I approve the job described above. () Yes. () No.

If no, reasons for disapproval/recommended modifications: _____

Physician Signature: _____

Date: _____

Physician Name (Please print) _____

Certification No.: _____