

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

REPORT TYPE ___ Initial ___ Progress ___ Closing

WORKER'S NAME _____

SS NO. _____ Employer Name _____

DOB _____ Employer Phone/Fax _____/_____

ACC. DATE _____ Insurer Name _____

EXAM DATE _____ Insurer Claim No. _____

Physician's Phone/Fax _____/_____ 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

Work Postures: Maximum tolerance in 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	()	()

Non-Material Handling: based on total hrs/day patient can work (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%

Comments: _____

Above work restrictions are: temporary _____ permanent _____ anticipated return to work without restrictions _____

Return to work modified duty start date: _____ Next reevaluation date: _____

Physician Signature: _____ Date: _____

Physician Name: (Please print) _____ Certification No.: _____

(Rev: 9/11/07)