DELAWARE WORKERS' COMPENSATION
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

CARRIER/TPA WC #: _____ DATE: _____

EMPLOYER: _____ FAX #: _____

EMPLOYEE: _____ **IS MODIFIED DUTY AVAILABLE: YES: ( ) NO: ( )**

IF AVAILABLE, FOR WHAT PERIOD OF TIME: _____ WEEKS / INDEFINITE: **( )**

JOB TITLE: _____ JOB DESCRIPTION: _____

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

Hours per day job available: (Check minimum and maximum) **(8) (6) (4) (2) (0)**

D.O.T. CLASSIFICATION OF WORK: (Check 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: _____ Squatting: _____ Standing: _____
Crawling: _____ Walking: _____ Climbing: _____
Driving: _____ Repeat arm motions: _____ Bending: _____
Turn/Twist: _____ Kneeling: _____ Foot controls: _____
Reaching up above shoulder: _____ Repetitive use of wrist/hands: _____

Comments: _____
_____

EMPLOYER:

Date job is available: _____

Comments: _____

Employer Signature: _____ **Date**: _____

PHYSICIAN: CHECK WHETHER YOU APPROVE THE JOB DESCRIBED ABOVE → **YES: ( ) NO: ( )**

If no, reasons for disapproval/recommended modifications: _____
_____

Physician Signature: _____ **Date**: _____

Physician Name: _____ 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 of such form.