DELAWARE INDUSTRIAL ACCIDENT BOARD
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

DATE OF REPORT: _____ I.A.B. CASE NO.: _____
EMPLOYER: _____ INSURER CLAIM NO.: _____
EMPLOYEE: _____ FACSIMILE NO.: _____

IS MODIFIED DUTY AVAILABLE: YES: ( ) NO: ( )

1. IF AVAILABLE, FOR WHAT PERIOD OF TIME:
   ( ) AVAILABLE FOR _____ WEEKS. ( ) INDEFINITELY. ( ) OTHER: _____
2. JOB DESCRIPTION:
   A. JOB TITLE: _____
   B. TYPE OF WORK: _____
   C. WORK ENVIRONMENT: _____
3. HOURS PER DAY JOB AVAILABLE (select maximum and minimum): (**8**) (**6**) (**4**) (**2**) (**0**)

D.O.T. CLASSIFICATION OF WORK (select 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. This involves sitting most of the time but may involve brief periods of walking or standing.
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 space provided regarding the following Postures / Positions for the available modified duty job:

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

EMPLOYER:

DATE JOB AVAILABLE: _____ WAGE RATE (IF KNOWN): _____
EMPLOYER COMMENTS: _____

_____

EMPLOYER SIGNATURE: _____ DATE: _____

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

IF NO, STATE REASONS FOR DISAPPROVAL / RECOMMENDED MODIFICATIONS: _____

_____

_____

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NAME (PRINT): _____ CERTIFIED PROVIDER: YES: ( ) NO: ( )

THE HEALTH CARE PROVIDER MUST COMPLETE HIS PORTION OF THIS FORM, SIGN AND RETURN IT TO THE NAMED EMPLOYER WITHIN FOURTEEN (14) DAYS OF THE NEXT DATE OF SERVICE AFTER THE PROVIDER'S RECEIPT OF THIS FORM BUT NO LATER THAN TWENTY-ONE (21) DAYS FROM THE PROVIDER'S RECEIPT OF SUCH FORM REGARDLESS OF WHEN THE NEXT DATE OF SERVICE OCCURS.