

DELAWARE INDUSTRIAL ACCIDENT BOARD
PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY
A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER, EMPLOYER AND INSURER

INITIAL REPORT: () PROGRESS REPORT: () CLOSING REPORT: ()

EMPLOYEE NAME: _____ EMPLOYER NAME: _____
DATE OF BIRTH: _____ EMPLOYER PHONE / FAX: _____
DATE OF INJURY: _____ INSURER NAME: _____
EXAM DATE: _____ INSURER CLAIM NO.: _____
PHYSICIAN PHONE / FAX: _____ INSURER PHONE / FAX: _____

INITIAL VISIT ONLY
Injured's description of accident / injury: _____

WORK RELATED MEDICAL DIAGNOSIS(ES): _____

TREATMENT PLAN:
Diagnostic Tests: _____
Procedures: _____
Therapy: _____
Medications: _____

Hours per day patient can work (select one): (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 TOLERANCES: Comment **as appropriate** in 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 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 (PRINT): _____ CERTIFIED PROVIDER: YES: () NO: ()