

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: \_\_\_\_\_

<u>Lift/Carry &amp; Push/Pull:</u>		<u>Lift/Carry</u>	<u>Push/Pull</u>
<u>D.O.T. Classification of Work</u>		<u>check one:</u>	<u>check one:</u>
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.: \_\_\_\_\_