Physician's Modified Work Information Sheet

To All Employees:

Please return this completed report directly to your supervisor within 24 hours of being seen by a physician, and prior to the start of your next scheduled work shift.

Attending Physician:

Pursuant to R.S. 39:1547, the Office of Risk Management is committed to accommodating injured workers so that they can timely return to work while facilitating their recovery. In order for the return to work to be successful, it is important that the accommodation fits the appropriate restriction(s) and limitation(s) that the employee should be observing. Please indicate your patient's work capabilities and any other comments you may have. Please fax a copy of the completed form to (225)368-3490.

Employee Name:_____DOB:_____Injury/Illness date:_____

Doctor Name (Printed): _____Phone Number:_____Claim#:_____

RETURN TO WORK FULL DUTY WITH NO RESTRICTIONS? YES NO DATE: _____

The following details the employee's current capabilities; (*please checkmark as appropriate)*

	1 to 2 lbs	3 to 5 lbs	6 to 10 lbs	11 to 20 lbs	21 to 30 lbs	31 to 40 lbs	41 + lbs
Lifting							
Carrying							
Push/pull							

	Minimal	Under 1 Hr	1-2 Hrs	2-3 Hrs	3-4 Hrs	4-5 Hrs	5-6 Hrs	8 hrs	12 hrs
Sitting									
Standing									
Walking									

	YES	NO
Squatting / Kneeling		
Bend/Twist at Waist		
Reaching		
Work above Shoulder		
Climbing		

List any other restrictions_____

Restrictions effective until (date) _____

Diagnosis: _____

Treatment Plan: _____

Date_____Signature of Attending Physician: _____

Date of Follow Up Appointment:_____ Patient signature_____