GENERAL DISTRIBUTION

WEST VIRGINIA
DIVISION OF CORRECTIONS
& REHABILITATION

NUMBER: 115.00

EFFECTIVE DATE: 16 August 2023

SUBJECT: WORKERS' COMPENSATION & RETURN-TO-WORK PROGRAM

POLICY DIRECTIVE

PURPOSE:

To provide appropriate guidelines and procedures for managing a work-related illness or injury of Division of Corrections and Rehabilitation employees; and provide a mechanism that allows employees an opportunity to continue as a valuable member of the workforce while recovering from a work-related illness or injury or non-work-related illness or injury.

REFERENCE:

WV Code §§23-4-1 *et seq.*; 143CSR1 (14.4.h.) and 143CSR3 Title 143 Legislative Rules of the West Virginia Division of Personnel; and WV Division of Personnel Policy DOP–P7 Worker's Compensation/Sick Leave.

RESPONSIBILITY:

No additional written instructions on this subject are required.

CANCELLATION:

Any previous written instruction on the subject including DCR Policy Directive 115.00, dated 01 January 2019; and DOC Policy Directive 315.02, dated 01 March 2012.

APPLICABILITY:

All facilities and work units within the Division of Corrections and Rehabilitation (DCR). This Policy is available for general distribution.

DEFINITIONS:

Employee: Any permanent status employee or temporary employee (including probationary employees) of the State of West Virginia working at Central Office, a correctional facility or other work unit within the West Virginia Division of Corrections

and Rehabilitation. For the purposes of this policy, this does not include contractors and their employees or volunteers.

Work-Related Illness or Injury: An injury or illness caused, contributed or significantly aggravated by events or exposures in the work environment. Work-related injuries occur on the job and as a direct result of the tasks allotted to the specific job. An injury for which the employee sought and received workers compensation benefits.

POLICY:

I. All on the job accidents and/or injuries must be reported verbally or in writing to the involved employee's supervisor **immediately (within 24 hours)**. In the event an injured employee is unable to report due to the severity of the injury, any employee who witnessed the accident and/or injury shall make the report to the injured employee's supervisor.

A. The supervisor will ensure that the injured employee receives proper medical treatment, including first aid, hospital care, and/or emergency transport.

B. If medical services are required, the supervisor or designee will provide the injured employee a West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease (**Attachment #1**) for completion by the treating medical provider and injured employee.

1. If the employee's injury is so severe that he/she cannot obtain the form, a family member of the injured employee, or the Superintendent or his/her designee may complete and submit the form.

2. As soon as possible, but no later than two (2) working days after receiving treatment, the involved employee will provide a copy of the completed form (**Attachment #1**) to the facility/work unit human resource section to process and submit to the State's Workers' Compensation insurer.

C. If the injured employee will be absent from work for three (3) or more days as a result of the injury, the facility/work unit human resources section will provide the injured employee an Initial Report of Injury Election of Option (**Attachment #2**) to designate the employee's choice to receive either sick leave or Temporary Total Disability (TTD) benefits for the period of absence.

D. If an injured employee does not seek medical treatment immediately after an work-related injury and later feels medical treatment is necessary, the injured employee must notify his/her immediate supervisor as soon as possible but no later than twenty-four (24) hours after medical care was obtained and submit a copy of the West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease (**Attachment #1**) to the facility/work unit human resources section for processing and submission.

E. If an employee is on duty away from his/her normal work site and is injured, the injury is to be reported to the supervisor where the injury occurred. It shall be the responsibility of that supervisor to complete and obtain the same forms as if he/she is the injured employee's immediate supervisor. The supervisor shall also be responsible for notifying the injured employee's normal work site of the injury as soon as possible and forwarding all of the required paperwork as soon as it is obtained.

II. If an employee develops an occupational disease as a result of his/her employment and seeks medical diagnosis and treatment, the employee is required to obtain a copy of the West Virginia Workers' Compensation Employees' and Physicians' Report of Occupational Injury or Disease (**Attachment #1**) that is completed by the treating medical provider and turn it in to his/her immediate supervisor within two (2) working days of the diagnosis. The immediate supervisor will submit the completed form to the facility/work unit human resources section who will complete the required paperwork and notify the State's Workers' Compensation insurer.

III. If an employee is required to be absent from work for extended periods of time due to a work-related illness or injury, it is that employee's responsibility to keep the facility or work unit informed as to his/her recovery process.

A. Within every thirty (30) days of absence from work, the employee shall contact his/her facility/work unit and provide the human resource section a Physician's/Practitioner's Statement – Form DOP-L3 (**Attachment #3**) completely filled out and signed by the treating physician/practitioner. If the Physician's/Practitioner's Statement covers a longer period of time than thirty (30) days, a new Statement shall not be required, but the employee is still required to make contact.

B. A current Physician's/Practitioner's Statement shall be provided by the employee each time a patient evaluation is made by the physician/practitioner while the employee is absent from work.

C. The treating physician/practitioner can use another form as long as it contains the same required information as the DOP-L3 Form and is completely filled out and signed by the physician/practitioner.

D. The employee shall also keep his or her facility/work unit updated on his or her medical progress by advising the human resources section of, but not limited to, any pending appointments, physical therapy, medical treatments, when the physician/practitioner will re-evaluate, and the prognosis of when he/she might be able to return to work.

E. Before an employee is allowed to return to work after recovering from a work-related illness or injury, he/she will have to be released by a qualified physician/practitioner. The release to return to work shall be in writing and signed and dated by the treating physician/practitioner. If the treating physician/practitioner determines the employee is unable to resume full duty employment but can return to less than full duty, the employee will be provided information on the **Return-To-Work Program**.

IV. In order to provide employees an opportunity to continue as a valuable member of the workforce while recovering from work-related illness or injury **or** a non-work-related illness or injury, the DCR offers a **Return-To-Work Program**. The Program is designed to minimize any adverse effects of an on-the-job injury or illness and ultimately return the employee to his/her original job quickly and safely if possible. This is intended to benefit an employee by promoting a speedy recovery, while keeping his/her work patterns and income consistent.

A. To ensure complete understanding of the Return-To-Work Program and that treating physician(s)/practitioner(s) are aware that modified work is available, the human resources section of each facility/work unit will create a packet consisting of the following documents (*with the specific employee's information filled in*). The employee is responsible for providing the Return-To-Work Packet to the treating physician/practitioner.

- Letter to Treating Physician (**Attachment #4**)
- Physician Statement of Physical Capabilities (**Attachment #5**)

B. The Superintendent or work unit supervisor or director, as appropriate, may allow an employee to return to work at less than full duty for a period of no more than thirty (30) days, with the terms of the return in writing. The employee may request to continue work at less than full duty beyond the approved period by submitting a request in writing and providing updated medical documentation at least five (5) days before the end of the approved period.

C. The Superintendent or work unit supervisor or director may deny a request to return or continue to work at less than full duty or with restrictions under conditions including, but not limited to, the following:

1. The employee cannot perform the essential duties of his or her job with or without accommodation;

2. The nature of the employee's job is such that it may aggravate the employee's medical condition:

3. A significant risk of substantial harm to the health or safety of the employee or others cannot be eliminated or reduced by reasonable accommodation; or,

4. The approval of the request would seriously impair the conduct of the agency's business.

D. A job duty or function is essential if removal of that function would fundamentally change the job. The following factors should be considered:

1. Does the position exist to perform that function? If yes, then it is an essential job function.

2. Can the function only be performed by a limited number of employees? If yes, then it is likely to be considered an essential job function.

3. Does the position require highly specialized skills? If the function is highly specialized it is likely to be considered an essential job function.

4. How much time does the employee spend performing the particular function? The more time spent on a function, the more likely it will be considered an essential job function.

5. What is the consequence of not performing the function? If failure to perform the function has adverse effects, it is likely to be considered an essential job function.

6. What is the work experience of the person who held the position in the past? This information will also be considered relevant in determining whether or not a job function is essential.

E. In considering the information provided on the Physician Statement of Physical Capabilities (**Attachment #5**) the following should be considered.

1. **Sedentary Work:** Sedentary work involves lifting no more than ten (10) pounds at a time and occasionally lifting or carrying articles like files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally, and other sedentary criteria are met.

2. **Light Work:** Light work involves lifting not more than twenty (20) pounds at a time, with frequent lifting or carrying of objects weighing up to ten (10) pounds. Although the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing or sitting more of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, one must have the ability to do substantially all of these activities. If someone can do light work, it is determined that he/she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

3. **Medium Work:** Medium work involves lifting no more than fifty (50) pounds at a time with frequent lifting or carrying of objects weighing up to twenty-five (25) pounds. If someone can do medium work, it is determined he or she can also do sedentary and light work.

4. **Heavy Work:** Heavy work involves lifting no more than one hundred (100) pounds at a time with frequent lifting or carrying of objects weighing up to fifty (50) pounds or more. If someone can do very heavy work, it is determined that he or she can also do heavy, medium, light and sedentary work.

5. **Very Heavy Work:** Very heavy work involves lifting objects weighing more than a hundred (100) pounds at a time with frequent lifting or carrying of objects weighing fifty (50) pounds or more. If someone can do very heavy work, it is determined that he or she can also do heavy, medium, light and sedentary work.

F. Prior to making a decision on an employee's request, the Superintendent or work unit supervisor or director, may require additional information from the employee's physician/practitioner or other physician/practitioner regarding the employee's ability to perform the essential duties of his or her job, with or without accommodations.

V. The designated facility or work unit human resources staff will act as a liaison between the DCR, the Division of Administrative Services (DAS), the injured worker, the attending physician/practitioner, and the state's workers' compensation insurer. Additional information on workers' compensation is available to human resources staff on the WV Division of Personnel Website.

VI. Occupational accidents, injuries, and property damage will be reviewed or investigated by the Safety Officer or higher authority as appropriate.

A. A person conducting an investigation will complete the investigation by gathering evidence and finding the cause of the accident, injury, and/or property damage.

B. Once the investigation is complete, the person conducting the investigation will complete a report concerning his/her findings along with suggestions of how to keep the accident, injury, and/or property damage from reoccurring and submit it to the Superintendent, or work unit supervisor or director as appropriate, with copies forwarded to the Director of Safety.

ATTACHMENT(S):

#1 Appendix C Encova Insurance - West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease (2 pages including instructions)

#2 WV Division of Personnel – Workers' Compensation Temporary Disability Benefits or Sick Leave Benefits – Initial Report of Injury Election of Option (2 pages)

#3 Physician's/Practitioner's Statement – Form DOP-L3

#4 Letter to Treating Physician template (to be printed on facility or agency letterhead)

#5 Encova Insurance Physician Statement of Physical Capabilities

APPROVED SIGNATURE: William K. Marshall III 08/16/2023

William K. Marshall, III Commissioner **Date**

APPENDIX C

encova INSURANCE

WEST VIRGINIA WORKERS' COMPENSATION EMPLOYEES' AND PHYSICIAN'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

For Encova use only
Claim number:
Team assigned:

SECTION I - EMPLOYEE'S CLAIM INFORMATION

1. Last name	First name		MI
2. Address			3. Telephone
City	State	ZIP	4. Social Security number
5. Date of birth	6. Sex ☐ M ☐ F		7. Marital status
8. Date of injury or last exposure	Time ☐ a.m. ☐ p.m.		9. Time you began work on date of injury ☐ a.m. ☐ p.m.
10. Date you stopped working due to injury			
11. Have you retired? ☐ Yes ☐ No	If "yes," what was the date you retired?		
12. Employer's name		Supervisor's name	
Address			
City	State	ZIP	Telephone
13. Job title/description			
14. Body parts injured			
15. Describe how your injury occurred (specify the cause, what you were doing and equipment/objects involved):			
16. Did injury occur on employer's property? ☐ Yes ☐ No Address where injury occurred			
17. Please identify any witnesses to your injury			

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other health care provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be valid as the original.

Employee's signature Date

SECTION II - ALL INFORMATION MUST BE COMPLETED BY INITIAL PROVIDER

1. Name of physician/hospital		2. FEIN/Social Security number	
3. Address			
City	State	ZIP	Telephone
4. Date of initial treatment		5. Date patient may return to work	
6. Have you advised the patient to remain off work four or more days? ☐ Yes If yes, indicate dates from to ☐ No If no, is the patient capable of ☐ Full duty ☐ Modified duty If the patient is capable of returning to modified duty, specify any limitations/restrictions			
7. Condition is a direct result of ☐ Occupational injury? ☐ Occupational disease? ☐ Non-occupational condition?			
8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No		If "yes," explain	
9. Description of injury or occupational disease			
10. Body part(s) injured		11. ICD10-CM diagnosis code(s) in order of severity	
12. Name of physician referred to		13. If the patient was hospitalized, where?	

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Physician's signature Date

General instructions for completing the "BI-1,"

"West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease"

Please read carefully.

BI-1, West Virginia Workers' Compensation Employees' and Physician's Report of Occupational Injury or Disease: To be completed by the claimant and the medical provider.

This form should not be used to file occupational pneumoconiosis or hearing loss claims.

To the claimant: Section I of this form must be completed by you. **When you have completed this form, make a copy for your records and give a copy to your employer.** The initial medical provider is responsible for completing Section II of this form. If you do not receive a decision on your claim within **14 days** after submitting the form, contact Encova Insurance. To be eligible for benefits, **a claim must be filed with Encova within six months** from and after the injury or death. If you have any questions, contact Encova at 866-452-7425 or visit our website at encova.com.

To the initial medical provider: Section II of this form must be completed by you. The timely provision of information regarding the claimant's condition is vital in deciding eligibility for benefits. Each answer should be as specific as possible. You should immediately send a copy of all records, office notes and test results regarding the claimant's exam to Encova. **Please forward the original completed form to Encova and provide a copy to the claimant.** If you have any questions, contact Encova at 866-452-7425 or visit our website at encova.com.

Special instructions for Section I	
Question 8	This date is defined as either the date you were injured or the date you were last exposed if you are filing an occupational disease claim.
Question 13	Provide your specific job title and describe the duties of the job you are currently working.
Question 15	Please provide as much detail as possible and attach additional pages if space is needed.

Special instructions for Section II	
Question 1, 2	The group and FEIN are required by Encova for billing purposes.
Question 8	Describe in detail what effect, if any, the claimant's previous health may have on this injury.

Please attach additional pages if space is needed and include any appropriate reports.

Return completed form to

Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151

When completing this form, enclose attachments if additional space is needed.

WORKERS' COMPENSATION TEMPORARY TOTAL
DISABILITY BENEFITS OR SICK LEAVE BENEFITS

INITIAL REPORT OF INJURY ELECTION OF OPTION

Employee Name: _____ Soc. Sec. No. (Last 4):_____

Date of Injury:_____ Claim No. (If Known):_____

Employer:_____ _____
(Department) (Division/Section)

To the Employee: ***Please submit this completed form to your employer.*** If you are absent from work due to a work-related injury, you must choose to receive ***either*** workers' compensation Temporary Total Disability benefits (TTD benefits) or paid sick leave, and annual leave upon exhaustion of sick leave, according to the Division of Personnel's (DOP) Workers' Compensation Temporary Total Disability Benefits Rule (143CSR3) and Workers' Compensation/Sick Leave policy (DOP-P7). If you elect to receive TTD benefits, you may use sick leave until you receive your initial TTD benefit payment. Upon receipt of the initial benefit payment, you are obligated to reimburse your employer the net value of the paid sick leave used. Leave balances will then be restored according to the provisions of this policy.

☐ **Option 1**

I elect to receive workers' compensation TTD benefits; however, I understand that I may use sick/annual leave ***only until*** I receive my initial TTD benefits payment. I understand that while receiving TTD benefits, I will be in a leave of absence without pay status. During this leave of absence without pay, I understand that I will continue to accrue tenure credit for a reduction in force calculation and for the calculation of annual increment pay. I will accrue annual leave. **I will not accrue** sick leave and **I will not be paid** for official holidays during this leave of absence without pay.

☐ **Option 2**

I elect to receive sick/annual leave benefits instead of workers' compensation TTD benefits for the period I am absent from work due to a work-related injury. While I am receiving paid leave benefits, I understand that I will continue to accrue annual leave, sick leave, and be paid for official holidays that occur during this period. I also understand that while I am receiving paid leave benefits, I will continue to accrue annual increment pay and years of service credit for increment calculation as well as tenure credit for a reduction in force calculation. After I exhaust my sick/annual leave, I understand that I am eligible to receive TTD benefits during any remaining period of absence from work due to a compensable injury. If I receive TTD benefits, I understand that while receiving these benefits, I will be in a leave of absence without pay status. During this leave of absence without pay, I understand that I will continue to accrue tenure credit for a reduction in force calculation and the calculation of annual increment pay. I

will accrue annual leave. **I will not accrue** sick leave and **I will not be paid** for official holidays during this leave of absence without pay.

Employee's Statement: I understand that I must choose **either** workers' compensation TTD benefits or paid sick/annual leave and that I am not legally entitled to both for the same period. I understand that if I elect to receive TTD benefits and choose to receive paid sick/annual leave until I receive my initial TTD benefits payment, I must reimburse the net value of the paid leave to my employer, who will then restore that leave. If I fail to reimburse my employer the net value of the paid leave used, I understand such amount will be deducted from future wage payments.

Employee's
Signature: _____ Date Submitted: _____

TO BE COMPLETED BY THE EMPLOYER - This document was received by:

Signature: _____ Date Received: _____

THE TERMS OF THE OPTIONS ARE BASED ON CURRENT RULES (07/01/2022, 143CSR1, and July 1, 2012, 143CSR3) AND ARE SUBJECT TO CHANGE THROUGH THE LEGISLATIVE RULE-MAKING PROCESS.

STATE OF WEST VIRGINIA
PHYSICIAN'S/PRACTITIONER'S STATEMENT

PATIENT'S NAME:	EXAM DATE:

PATIENT WAS: ❑ Under my professional care FROM _____ TO _____

❑ Hospitalized FROM _____ TO _____

Dates of treatment: _____

PERIOD OF INCAPACITY (required): FROM _____ TO _____

❑ NO ❑ YES During this time, will or did the patient need care?

If yes, explain the care needed by the patient and why such care is/was medically necessary. Use reverse side if needed.

_____

_____

_____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

EMPLOYEE LIMITATIONS/RESTRICTIONS (skip if patient was a family member of the employee):

Patient was or may be able to resume full duty employment, with no restrictions in work activities, on:

Date: _____

❑ NO ❑ YES If unable to presently return to full duty employment, can the patient return to less than full duty?

If yes, what is the period of partial incapacity? FROM _____ TO _____

Describe in detail any limitations or restrictions on the ability of the employee to work. List any assistive devices or equipment, or any accommodation the employee requires to perform his/her job. Use reverse side if needed.

_____

_____

_____

❑ NO ❑ YES Will this condition permanently prevent the employee from performing his/her duties?

PHYSICIAN/PRACTITIONER INFORMATION:

NAME OF PRACTICE: TELEPHONE:

TYPE OF PRACTICE/MEDICAL SPECIALITY:

ADDRESS:

SIGNATURE:

NOTE: When requesting a medical leave of absence without pay under the Division of Personnel's *Administrative Rule*, W. VA. CODE R. § 143-1-1 *et seq.*, and/or leave with or without pay under the federal Family and Medical Leave or State Parental Leave Acts, certification forms DOP-L5 or DOP-L6, as applicable, may be required if additional information is needed.

(*Facility or Agency Letterhead*)

Date

Employee Name: _____

Claim Number: _____

Dear Treating Physician:

Please be advised that the West Virginia Division of Corrections and Rehabilitation has a Return-to-Work Program. This program is designed to return an employee to the workplace as soon as medically possible. If the employee is unable to return to work in his/her original job, we will make every effort to return him/her to modified duties or an alternative position. We will ensure that this position adheres to all medical restrictions you prescribe.

As the Treating Physician, your assistance is significant in the success of our Return-to-Work Program. Attached you will find Physician Statement of Physical Capabilities. If modified/alternative employment is warranted, please document the worker's abilities/limitations on the Form and we will accommodate as needed. If a return to work is not feasible in any manner at this time, please advise when the worker's return to work abilities will be reassessed.

Thank you in advance for your participation in our efforts to return our worker to a safe and productive workplace. We look forward to working in partnership with you. Please feel free to contact me directly at 304-XXX-XXXX, if you have any questions or concerns regarding this correspondence. Additionally, you may forward your reply to my attention via fax at 304-XXX-XXXX or email at XXXX@wv.gov. Thank you again for your time, assistance, and response.

Sincerely,

Name
Title

Enclosed: Physician Statement of Physical Capabilities Form

encova INSURANCE

PHYSICIAN STATEMENT OF PHYSICAL CAPABILITIES

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

Claimant name | Claimant number | Date of injury

Please complete this form after your examination of the patient. Indicate the patient's capabilities, including work hours, duties, environmental factors and any other information pertinent to this employee's recovery and early return to work.

Medical diagnosis

Please indicate the extent to which the employee can perform the following work postures and work activities during the usual workday.

	>67% of workday	34% - 66% of workday	6% - 33% of workday	<5% of workday	0% of workday
Standing	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Sitting	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Walking	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Climbing	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Kneeling	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never

Please indicate the extent to which the employee can perform the following:
(C - Constantly = greater than 67% F - Frequently = 34% to 66% O - Occasionally = 6% to 33% R - Rarely = Less than 5% N - Never = 0%)

Lifting/carrying	C	F	O	R	N
5 lbs. or less					
5–10 lbs.					
11–20 lbs.					
21–40 lbs.					
41–60 lbs.					
61–100 lbs.					
100+ lbs.					

Activity					
Bend					
Squat					
Twist/turn					
Crawl					
Reach above shoulder					
Type/keyboard					
Joystick/ hand controls					
Vibration					

Comments

Pushing/pulling	C	F	O	R	N
5 lbs. or less					
5–10 lbs.					
11–20 lbs.					
21–40 lbs.					
41–60 lbs.					
61–100 lbs.					
100+ lbs.					

Driving

Automatic drive ☐ ☐ ☐ ☐ ☐

Standard drive ☐ ☐ ☐ ☐ ☐

Upper extremities	Yes		No	
Simple grasping	☐ Right	☐ Left	☐ Right	☐ Left
Pushing/pulling	☐ Right	☐ Left	☐ Right	☐ Left

Operate foot controls	Yes		No	
	☐ Right	☐ Left	☐ Right	☐ Left
Simultaneous	☐ Yes		☐ No	

Physician name | Physician telephone

Date released with above restrictions | Date released for full-duty work

Projected date for MMI | Date and time of next appointment

Physician signature | Date