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:_____

Lift/Carry & Push/Pull: D.O.T. Classification of Work		Lift/Carry check one:	Push/Pull check one:
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.:_____

(Rev: 9/11/07)

PROVIDER FORM