

DELAWARE WORKERS' COMPENSATION  
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

DATE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ EMPLOYEE: \_\_\_\_\_

IS MODIFIED DUTY AVAILABLE: \_\_\_\_ Yes \_\_\_\_ No EMPLOYER FAX #: \_\_\_\_\_

IF AVAILABLE, FOR WHAT PERIOD OF TIME: \_\_\_\_ Weeks \_\_\_\_ Indefinite

JOB TITLE: \_\_\_\_\_

JOB DESCRIPTION: \_\_\_\_\_

ENVIRONMENT/WORKING CONDITIONS (e.g., Temperature): \_\_\_\_\_

**ADDITIONAL INFORMATION:**

Hrs. per day job available: (circle minimum and maximum): 8      6      4      2      0

Work Postures: Maximum required 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	( )	( )

Based on the total hrs. per day job is available, this job requires (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%

EMPLOYER: Date job is available: \_\_\_\_\_

Comments: \_\_\_\_\_

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICIAN: I approve the job described above. ( ) Yes. ( ) No.

If no, reasons for disapproval/recommended modifications: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Name (Please print) \_\_\_\_\_

Certification No.: \_\_\_\_\_