Medical Provider Work Related Injury/Illness Report

Date of Service: _____

Patient Name: _____

PLEASE FAX IMMEDIATELY TO BOTH:

Spearfish School District Fax: (605)-717-1200

Claims Assocates Insurance Companies Fax: (605-333-9835

Employer: **Spearfish School District** Notified: ☐ Yes ☐ No

Diagnosis:		Is condition work related? ☐ Yes ☐ No	
Treatment Plan:			
Medication(s):			

Date of most recent examination by this office: __/__/____. The next scheduled visit is: ☐ as needed OR __/__/____.
Month/Day/Year Month/Day/Year

1. ☐ Recommended his/her return to work with no limitations on _____.
Date

2. ☐ He/She may return to work on _____ with the following limitations:
Date

DEGREE	LIMITATIONS
☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, 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 only occasionally and other sedentary criteria are met. ☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls. ☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds. ☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds. ☐ **Very Heavy Work.** Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.	1. In an 8 hour work day, patient may: a. Stand/walk ☐ None ☐ 4-6 Hours ☐ 1-4 Hours ☐ 6-8 Hours b. Sit ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours c. Drive ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours 2. Patient may use hands for repetitive: ☐ Single grasping ☐ Pushing and pulling ☐ Fine manipulation 3. Patient may use feet for repetitive movement as in operating foot controls: ☐ Yes ☐ No 4. Patient is able to: Frequently / Occasionally / Not at all a. Bend ☐ ☐ ☐ b. Squat ☐ ☐ ☐ c. Climb ☐ ☐ ☐

OTHER INSTRUCTIONS AND/OR LIMITATIONS:

3. ☐ These restrictions are in effect until _____ or until patient is reevaluated.
Date

4. ☐ He/She is totally incapacitated at this time. Patient will be reevaluated on_____.
Date

Treating Facility Name:				
	Please Print			
Physician's Signature:		Phone No:	(___)	_____

RELEASE OF INFORMATION AUTHORIZATION

I authorize the treating physician to release copies of my medical records including lab and x-ray reports to the above-named employer and the insurance company. I certify that I have received a copy of this report.

Employee's Signature:		Date:	