

Work Related Injury/Illness Report

PLEASE FAX IMMEDIATELY TO BOTH:
 CENTERVILLE CSD: (641) 856-0672
 EMC Insurance WC Claims Fax: (888) 992-8214

Date of Service: _____
 Patient Name: _____
 Employer: CENTERVILLE CSD

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																
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, 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.	1. In an 8 hour work day, patient may: a. Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 4-6 Hours <input type="checkbox"/> 1-4 Hours <input type="checkbox"/> 6-8 Hours b. Sit <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours c. Drive <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours 2. Patient may use hands for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation 3. Patient may use feet for repetitive movement as in operating foot controls: <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Patient is able to: <table style="width: 100%; border: none;"> <tr> <td></td> <td style="text-align: center;"><u>Frequently</u></td> <td style="text-align: center;"><u>Occasionally</u></td> <td style="text-align: center;"><u>Not at all</u></td> </tr> <tr> <td>a. Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<u>Frequently</u>	<u>Occasionally</u>	<u>Not at all</u>	a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> 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.																	
<input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds.																	
<input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.																	
<input type="checkbox"/> Very Heavy Work. Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.																	

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: _____