



Bureau of Workers' Compensation

Physician's Report of Work Ability

Instructions

- Physician must complete this form when the injured worker is under work restrictions or is temporarily totally disabled.
- You must send or fax a copy of the completed form to the managed care organization (MCO) and a copy given to the injured worker at time of exam.
- You may use any other physician-generated document provided that the substitute document contains, at a minimum, the data elements on the MEDCO-14.
- If injured worker is employed by a self-insuring employer complete this form and mail or fax it to the self-insuring employer.

Fax Note:

To	From
Toll-free phone number	Phone number
Toll-free fax number	Fax number

Injured worker name	Claim number	SSN if claim number unknown	Date of injury / /
Injured worker occupation		Employer name	

WORK ACTIVITY	<input type="checkbox"/> May return to work (RTW) with no restrictions on _____	Work/Non-Work Capabilities <table border="1"> <thead> <tr> <th></th> <th>None at all 0%</th> <th>Occasional 1-33% 4-6</th> <th>Frequent 34-66% 6-12</th> <th>Continuous 67-100% >12</th> </tr> </thead> <tbody> <tr> <td>% of Workday (8 hr)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Repetitions per hr</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Lift/Carry</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Up to 10 lbs.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>11-20 lbs.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>21-50 lbs.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>51-100 lbs.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Bending.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Twist/turn.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Reach below knee.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Push/pull.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Squat/kneel.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Stand/walk.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sit.....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>No lifting above shoulders..</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>					None at all 0%	Occasional 1-33% 4-6	Frequent 34-66% 6-12	Continuous 67-100% >12	% of Workday (8 hr)					Repetitions per hr					Lift/Carry					Up to 10 lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	11-20 lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21-50 lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	51-100 lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bending.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist/turn.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach below knee.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Push/pull.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Squat/kneel.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stand/walk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sit.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No lifting above shoulders..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> May RTW with restrictions due to work-related injury/disease from _____ to _____ (complete work/non-work capabilities on the right). Work restrictions apply to work and non-work activity. If restrictions cannot be met at work, then injured worker is recommended to be off work.																																																																																					
The restrictions are <input type="checkbox"/> permanent <input type="checkbox"/> temporary? If temporary, how long? _____																																																																																					
<input type="checkbox"/> Is totally disabled from work from _____ to _____ Please explain in the space provided below why the injured worker is unable to work, due to work-related injury/disease. List ICD-9 codes for the allowed conditions being treated which prevent return to work. _____ _____ _____ Estimated RTW date _____																																																																																					

Hand restrictions Left Right
 Must wear splint
 No lifting greater than _____ lbs
 No repetitive activities
 No work with hot or cold substances

No use of Left Right
 Arm
 Hand
 Finger _____
 Other _____

Change positions every _____ Work activity as splint/bandage permits
 Avoid driving Keep wound clean/dry Limit working to _____ Hrs./Day

Physician's further explanation of work abilities or why the injured worker is unable to perform any work: _____

MMI	Has the work-related injury(s) or occupational disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement): <input type="checkbox"/> Yes <input type="checkbox"/> No
	<p style="text-align: center;">▶ Note: Periodic medical treatment may still be requested and provided.</p> IF YES, give date _____ IF NO, please explain (attach additional sheet if necessary)

REHAB	<input type="checkbox"/> Check if vocational rehabilitation return to work services are indicated.
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Physician name and address (please print, type or stamp)

Date of this exam / /	Follow-up appointment Date / /	Time
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I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both.

Physician signature (mandatory) _____ Date / /