PHYSICIAN'S FORM
INSTRUCTIONS/DEFINITIONS

The use of this form is required by the Delaware Workers' Compensation Statute, 19 Del.C. §2322E, to report all information specific to this workers' compensation injury.
Complete all applicable fields. Your office notes and records do not replace this form.

1. **Report Type:** Check "Initial" if this is the first visit related to this described injury. Check "Progress" when there has been any material change in the injured employee's physical capability which impacts the employee's return to work status. Check "Closing" if: injured worker is discharged from care.

2. **Case Information:**
   - **Injured Worker's Name:** Name of the injured worker.
   - **Date of Birth:** The injured worker's date of birth.
   - **Date of Injury:** Date of this injury.
   - **Exam Date:** Date of office visit if applicable.
   - **Physician's Phone/Fax:** The telephone and fax numbers of the physician completing this form.
   - **Employer Name:** The name of the employer associated with the claim.
   - **Employer Phone/Fax:** The telephone and fax numbers of the employer.
   - **Insurer Name:** The name of the insurance carrier associated with the claim, if known.
   - **Insurer Claim #:** The claim number assigned by the insurance carrier or self-insured employer, if known.
   - **Insurer Phone/Fax:** The telephone and fax numbers of the insurance carrier associated with the claim, if known.

3. **Initial Visit:** Relate in injured worker's words description of accident/injury.

4. **Work Related Medical Diagnosis(es):** State the injured worker's work related medical diagnosis(es).

5. **Treatment Plan:** Complete all applicable portions regarding treatment. Indicate frequency and duration.
   - **Diagnostic tools/tests:** EMG, MRI, CT-scan, etc.
   - **Procedures:** Any medical procedure including surgical procedures, castings, etc.
   - **Therapy:** Physical therapy, occupational therapy, home exercise, etc., including plan specifications.
   - **Medications:** Antibiotics, analgesics, anti-inflammatory drugs, etc.
   - **Other:** Any treatment not covered above.

6. **Hours Per Day Patient Can Work:** Circle the number of hours applicable to this patient.

7. **D.O.T. Classification of Work:** Circle the classification of work applicable to this patient.

8. **Work Postures/Positional Tolerances:** Comment as appropriate in the space provided regarding the patient's abilities/limitations for the postures/positions listed.

9. **Comments:** To be used to explain/clarify any information required by this form.

10. **Restrictions:** Check applicable category.

11. **Return to Work:** Provide regular duty/modified duty start date.

12. **Reevaluation Date:** Provide date of next evaluation.

13. **Physician Information:** Type or print the name of the physician and circle "yes" or "no" as to whether the physician is a Certified Provider. The health care provider most responsible for the treatment of the employee's work-related injury must sign and date the report.

The health care provider most responsible for the treatment of the employee's work-related injury shall complete and submit, as expeditiously as possible and not later than 10 days after the date of first evaluation or treatment, a report of employee condition and limitations, on a form adopted for that purpose pursuant to this section, and shall expeditiously provide copies of the report of employee condition and limitations to the employee, the employer and the employer's insurance carrier, if applicable, as required by 19 Del. C. §2322E(b).

DELAWARE WORKERS' COMPENSATION
PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY
A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER, EMPLOYER AND THE INSURER

REPORT TYPE _X_ Initial ___Progress ___Closing

WORKER'S NAME John Doe

		Employer Name	XYZ Manufacturing
DOB	01/25/78	Employer Phone/Fax	302-555-5555 / 302-555-5566
Date of Injury	12/02/08	Insurer Name	ABC ED Insurance
EXAM DATE	12/05/08	Insurer Claim No.	1a2c3y3b3g
Physician's Phone/Fax	302-555-4444	Insurer Phone/Fax	302-555-4545 / 302-555-5454

INITIAL VISIT ONLY
Injured worker's description of accident/injury Injured back lifting a box from the floor

WORK RELATED MEDICAL DIAGNOSIS (ES) Lumbosacral Strain

TREATMENT PLAN:
Diagnostic Tests X-rays
Procedures None
Therapy Physical Therapy 3x / week for 4 weeks
Medications Naprosyn, Flexiril

Hrs. per day patient can work: (circle one) (8) 6 4 2 0

D.O.T. Classification of Work (Circle one)

Sedentary Exerting up to 10 lbs. of force *occasionally* and/or a negligible amount of force *frequently* to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.

(Light) Exerting up to 20 lbs. of force *occasionally* and/or up to 10 lbs. of force *frequently* and/or negligible amount of force *constantly* to move objects. Physical demand requirements are in excess of those for Sedentary Work.

Medium Exerting 20 to 50 lbs. of force *occasionally* and/or 10 to 25 lbs. of force *frequently* and or greater than negligible up to 10 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Light Work.

Heavy Exerting 50 to 100 lbs. of force *occasionally* and/or 25 to 50 lbs. of force *frequently* and/or 10 to 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Medium Work.

Very Heavy Exerting in excess of 100 lbs. of force *occasionally* and/or in excess of 50 lbs. of force *frequently* and/or in excess of 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Heavy Work.

Definitions:
Occasionally: activity or condition exists up to 1/3 of the time
Frequently: activity or condition exists from 1/3 to 2/3 of the time
Constantly: activity or condition exists 2/3 or more of the time

Work Postures/Positional tolerances: Comment **as appropriate** in the space provided regarding the patient's abilities/limitations for the following Postures/Positions. (e.g. Sitting: No more than 30 minutes continuously)

Sitting:	Limit to 30 minutes continuously	Squatting:	Safe without weight
Standing:		Crawling:	
Walking:		Climbing:	
Driving:		Repeated arm motions:	
Bending:	No bending at waist	Repetitive use of wrist/hands:	
Turn/Twist:	Limit to 1-2x / hour	Reaching up above shoulder:	
Kneeling:		Foot controls:	

Comments:

Above safe work capacities are: temporary _X_ permanent _____ anticipate full duty release _____

Return to work modified duty start date: Immediately

RELEASE TO FULL DUTY WITH NO RESTRICTIONS (Please Circle) YES (Start date_____) NO

Physician Signature: [signature] Date: 12/05/08

Physician Name: (Please print) James Physician, M.D. Certified Provider: (YES) NO

PROVIDER FORM Revised 10/21/2009