Report of Workability

PLEASE FAX IMMEDIATELY TO:
EMC Insurance Companies: 1-888-992-6132

Date of Service: ________________ Date of Injury: ____________
Patient Name: ________________ Claim #: ____________
Employer: ________________ Date of Birth: ____________

Diagnosis/ICD9 Code: Is condition work related? ☐ Yes ☐ No

Treatment Plan:

Medications:

Date of most recent examination by this office: ___/___/_____. The next scheduled visit is: ☐ as needed OR ___/___/_____

1. ☐ Recommended his/her return to work with no limitations on _____________.
2. ☐ He/She may return to work on _____________ with the following limitations

DEGREE	LIMITATIONS
O **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. O **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 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. O **Medium Work**. Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds. O **Heavy Work**. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds. O **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 ☐ 1-4 Hours ☐ 4-6 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 & 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 ☐ ☐ ☐

PRE-EXISTING OR OTHER CONDITIONS THAT AFFECT THIS INJURY: ____________________________________

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

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

NAME (Type or Print)	SIGNATURE	DEGREE
ADDRESS	STATE	LICENSE #/REGISTRATION #:
CITY STATE ZIP CODE	PHONE # (include area code)	DATE SIGNED

INSTRUCTIONS FOR COMPLETING REPORT OF WORK ABILITY

Each health care provider directing the course of treatment for an employee who alleges to have incurred an injury on the job must complete a Report of Work Ability within 10 days of a request for a Report of Work Ability from the insurer, or at the applicable interval (Minn. Rules 5221.0410, subp. 6):

1. every visit if visits are less frequent that one every two weeks;

2. every 2 weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; and

3. upon expiration of the ending or review date of the restrictions specified in a previous Report of Work Ability.

The Report of Work Ability must either be on this form or in a report that contains the same information. The Report of Work Ability must:

- Identify the employee by name, WID or social security number, and date of injury.

- Identify the employer at the time of the employee's claimed work injury.

- If known, identify the workers' compensation insurer at the time of the claimed injury, or the workers' compensation third-party administrator. Also indicate this workers' compensation payer's claim number.

- Indicate the date of the most recent examination by this office. The Report of Work Ability should be completed based on this evaluation.

- Identify the appropriate option which best describes the employee's current ability to work by checking box 1, 2, or 3.

  1. If the employee is able to work without restrictions, fill in the beginning date.

  2. If the employee is able to work with restrictions, fill in the date any restriction of work activity is to begin and the anticipated ending or review date. Describe any restrictions in functional terms (e.g., employee can lift up to 20 pounds, 15 times per hour; should have 10 minute break every hour).

  3. If the employee is unable to work at all, fill in the date the restriction of work activity is to begin and the anticipated ending or review date.

- Indicate the date of the next scheduled visit or indicate that additional visits will be scheduled as needed.

- Identify the health care provider completing the report by name, professional degree, license or registration number, address and phone number.

- Include the signature of the health care provider and date of the report.

The health care provider must provide the Report of Work Ability to the employee and place a copy in the medical record.

If you have questions, please call the claim representative or the Department of Labor and Industry, Workers' Compensation Division at (651) 284-5030 or 1-800-342-5354.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.