



Better Workers' Compensation
Built with you in mind

INSTRUCTIONS:

- Physician must complete this form when the injured worker is under work restrictions or is temporarily totally disabled.
- A copy of the completed form must be sent/faxed to the MCO and a copy given to the injured worker at time of exam.
- Any other physician-generated document may be used 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 to the self-insuring employer.

Physician's Report of WORK ABILITY

FAX NOTE:

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

This form is now available online at: www.ohioabc.com

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

WORK ACTIVITY	<input type="checkbox"/> May RTW with no restrictions on _____ <input type="checkbox"/> May RTW with restrictions 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 _____	<table border="1"> <thead> <tr> <th colspan="5">Work/Non-Work Capabilities</th> </tr> <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 colspan="5">% of Workday (8hr) Repetitions per hr</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>	Work/Non-Work Capabilities						None at all 0%	Occasional 1-33% 4-6	Frequent 34-66% 6-12	Continuous 67-100% >12	% of Workday (8hr) 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"/>
	Work/Non-Work Capabilities																																																																																	
		None at all 0%	Occasional 1-33% 4-6	Frequent 34-66% 6-12	Continuous 67-100% >12																																																																													
% of Workday (8hr) 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"/>																																																																														
	Hand restrictions <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Must wear splint <input type="checkbox"/> Arm <input type="checkbox"/> No lifting greater than _____ lbs <input type="checkbox"/> Hand <input type="checkbox"/> No repetitive activities <input type="checkbox"/> Finger _____ <input type="checkbox"/> No work with hot or cold substances <input type="checkbox"/> Other _____																																																																																	
	<input type="checkbox"/> Change positions every _____ <input type="checkbox"/> Work activity as splint/bandage permits <input type="checkbox"/> Avoid driving <input type="checkbox"/> Keep wound clean/dry <input type="checkbox"/> 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 ► Note: Periodic medical treatment may still be requested and provided.
	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.
--------------	--

Physician name and address (please print, type or stamp)

Date of this exam / /	Follow-up appointment Date / /	Time
--------------------------	-----------------------------------	------

I certify that 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 / /