

# Broome County Office of Risk & Insurance Management

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## Treating Physician's Workers' Compensation Report

To the employee: You must give this form to your physician at each visit

**EMPLOYEE NAME** \_\_\_\_\_  
**DEPT. AND DIVISION** \_\_\_\_\_  
**DATE OF INJURY** \_\_\_\_\_

### For Physician use only

- In your medical opinion is this injury related to the individual's job?  Yes  No
- Current degree of disability (Please Circle) Mild (25%) Moderate (50%) Marked (75%) Total (100%)
- Taking into consideration the degree of disability you identified the employee:
  - Can return to work without restrictions
  - Cannot return to work until \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
  - Return to work with restrictions indicated below effective \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ through \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Broome County has a comprehensive modified duty program & can accommodate most restrictions. The information provided in this form will be utilized to temporarily assign county employees to modified duty. Please explain in detail in the "Additional Comments" the nature of your patient's limitation in terms of Hours / Weight. / Range of Motion, etc.

### ADDITIONAL COMMENTS

- |                             |                                  |                                       |                         |                 |
|-----------------------------|----------------------------------|---------------------------------------|-------------------------|-----------------|
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | PUSHING                 | _____           |
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | PULLING                 | _____           |
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | BENDING                 | _____           |
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | STOOPING                | _____           |
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | SITTING                 | _____           |
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | STANDING                | _____           |
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | TWISTING                | _____           |
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | CLIMBING                | _____           |
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | KNEELING                | _____           |
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | LIFTING                 | _____ Lbs. Max. |
| <input type="checkbox"/> NO | <input type="checkbox"/> LIMITED | <input type="checkbox"/> UNRESTRICTED | <b>OVERHEAD LIFTING</b> | _____ Lbs. Max. |

Additional restrictions: \_\_\_\_\_

**Authorization for the following treatment/test is hereby requested:** \_\_\_\_\_

Date of this Exam: \_\_\_\_\_ Date of Next Appointment: \_\_\_\_\_

Physician Signature : \_\_\_\_\_

Physician's Name, Address and Phone #: \_\_\_\_\_

Please Print