BWC
Bureau of Workers' Compensation
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www.ohiobwc.com

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

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

WORK ACTIVITY

☐ May RTW with no restrictions on _____

☐ 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 ☐ permanent ☐ temporary? If temporary, how long? _____

☐ 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 _____

Work/Non-Work Capabilities

% of Workday (8hr) / Repetitions per hr	None at all 0%	Occasional 1-33% 4-5	Frequent 34-66% 6-12	Continuous 67-100% >12
Lift/Carry				
Up to 10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21-50 lbs.	☐	☐	☐	☐
51-100 lbs.	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐
Reach below knee	☐	☐	☐	☐
Push/pull	☐	☐	☐	☐
Squat/kneel	☐	☐	☐	☐
Stand/walk	☐	☐	☐	☐
Sit	☐	☐	☐	☐
No lifting above shoulders	☐	☐	☐	☐

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): ☐ Yes ☐ 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

☐ **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** / /