

EMPLOYER'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.

1. Case Information:

- **Employer Name:** The name of the employer associated with the claim.
- **Employee Name:** Name of the injured worker.
- **Modification Duty Information:** Complete all applicable fields
- **Employer Fax:** The telephone and fax numbers of the employer.
- **Job Title:** Provide job title for position available.
- **Job Description:** Provide description of physical requirements of job duties for position available.
- **Environment/Working Conditions:** Identify any environmental factors relevant to position available.

2. Hours Per Day Job Available: Circle the number of hours applicable.

3. Additional Information: Circle the applicable work status categories for the position available, and comment as appropriate in the space provided regarding the work postures/positional requirements for the modified duty job available.

4. Employer: Provide job availability date.

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

6. Employer Information: The person responsible for completing this form on behalf of the employer must sign and date this form.

WITHIN FOURTEEN (14) DAYS OF RECEIVING THE INITIAL "PHYSICIAN'S REPORT OF WORKERS' COMPENSATION INJURY," THE EMPLOYER SHALL PROVIDE THIS FORM TO THE HEALTH CARE PROVIDER/PHYSICIAN WHO ISSUED THE AFOREMENTIONED REPORT AND THE EMPLOYER'S INSURANCE CARRIER AS REQUIRED BY 19 DEL.C. §2322E(D).

IF THE "PHYSICIAN'S REPORT OF WORKERS' COMPENSATION INJURY" RELEASES THE EMPLOYEE TO FULL DUTY, DO NOT COMPLETE THIS FORM.

THE HEALTH CARE PROVIDER/PHYSICIAN MUST COMPLETE HIS/HER PORTION OF THIS FORM AND SIGN AND RETURN IT TO THE EMPLOYER WITHIN FOURTEEN (14) DAYS OF THE NEXT DATE OF SERVICE AFTER THE PHYSICIAN'S RECEIPT OF THE FORM FROM THE EMPLOYER, BUT NOT LATER THAN TWENTY-ONE (21) DAYS FROM THE PHYSICIAN'S RECEIPT OF SUCH FORM.

DELAWARE WORKERS' COMPENSATION
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

DATE: _____

EMPLOYER: _____ FAX#: _____

EMPLOYEE: _____

IS MODIFIED DUTY AVAILABLE: Yes No

IF AVAILABLE, FOR WHAT PERIOD OF TIME: _____ Weeks _____ Indefinite

JOB TITLE: _____

JOB DESCRIPTION: _____

ENVIRONMENT/WORKING CONDITIONS (e.g., Temperature): _____

Hrs. per day job available: (circle minimum and maximum) 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 requirements: Comment **as appropriate** in the space provided regarding the following Postures/Positions for the modified duty job available.

Sitting: _____ Squatting: _____ Standing: _____
Crawling: _____ Walking: _____ Climbing: _____
Driving: _____ Repeated arm motions: _____ Bending: _____
Turn/Twist: _____ Kneeling: _____ Foot controls: _____
Reaching up above shoulder: _____ Repetitive use of wrist/hands: _____

Comments: _____

EMPLOYER: Date job is available: _____

Comments: _____

Employer Signature: _____ Date: _____

PHYSICIAN: I approve the job described above. () Yes. () No.

If no, reasons for disapproval/recommended modifications: _____

Physician Signature: _____ Date: _____

Physician Name (Please print) _____ Certified provider: YES NO

The Health Care Provider/Physician MUST complete his/her portion of this form and SIGN and RETURN it to the EMPLOYER within fourteen (14) days of the next date of service after the HC Provider/Physician's receipt of the form from the employer, but not later than twenty-one (21) days from the HC Provider/Physician's receipt off such form.