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| --- |
| **Claim Information:**  |
| Employee Name | Personnel Number | Date of Injury | Agency |
|       |       |       |       |
| **Instructions to the Health Care Provider:** |
| Please complete this form after every medical visit. The employer tries to accommodate work restrictions to return employees to work as soon as possible in some capacity, **regardless of the employee’s regular job duties.** Please note any restrictions below to allow the employer to determine if work is available. Please provide the completed form to the injured employee at the conclusion of the appointment to return to the employer, and you may fax it to Health Options & Management Services, Inc. (HOMS) at 717.732.4080.  |
| **Today’s Appointment:**  |
| Today’s Date | Time In | Time Out | First Visit | Next Appointment |
|       |  |  | [ ]  Yes [ ]  No |  |
| **Medical Facts:** |
| Diagnosis/Cause of Injury | Prognosis |
|       |  |
| Chief Complaint | Medications Prescribed |
|       |  |
| **Return to Work Information:**  |
| [ ]  Return with no restrictions on \_\_\_\_\_\_\_\_\_\_\_.[ ]  Return to full-time work **with restrictions indicated below** on \_\_\_\_\_\_\_\_\_\_\_\*.[ ]  Return to part-time work \_\_\_ hours per day **with restrictions indicated below** on \_\_\_\_\_\_\_\_\_\_\_\*.[ ]  May not return to work at this time; anticipated return to work with/without restrictions on \_\_\_\_\_\_\_\_\_\_.\* Anticipated return to **full duty** work on \_\_\_\_\_\_\_\_\_\_\_. |
| **Restrictions:** Complete **only** if there are restrictions, using an 8-hour day. |

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| --- | --- | --- | --- | --- | --- |
| **Ability to:** | **Hours Per Day** |  |  | **Ability to Use** **Upper Extremity/Hand:** | **Hours Per Day** |
| 0-1 | 1-3 | 3-6 | 6-8 |  |  | 0-1 | 1-3 | 3-6 | 6-8 |
| Sit |  |  |  |  |  |  | **Applies to (circle):** **RIGHT LEFT BOTH** |
| Stand |  |  |  |  |  |  | Repetitive |  |  |  |  |
| Walk |  |  |  |  |  |  | Fine Manipulation |  |  |  |  |
| Climb |  |  |  |  |  |  | Fingering |  |  |  |  |
| Lift |  |  |  |  |  |  | Simple Grasp |  |  |  |  |
| Kneel |  |  |  |  |  |  | Firm Grasp |  |  |  |  |
| Crawl |  |  |  |  |  |  | Push/Pull Seated |  |  |  |  |
| Squat/Crouch |  |  |  |  |  |  | Push/Pull Standing |  |  |  |  |
| Bend At Waist |  |  |  |  |  |  | Reach Above Shoulder |  |  |  |  |
| Twist/Rotate |  |  |  |  |  |  |  |  |  |  |  |
| Drive |  |  |  |  |  |  | **Ability to Use** **Lower Extremity Foot/Leg:** | **Hours Per Day** |
|  |  |  |  |  |  |  | 0-1 | 1-3 | 3-6 | 6-8 |
| **Ability to:** | **Pounds** |  | **Applies to (circle):** **RIGHT LEFT BOTH** |
| 0-10 | 11-25 | 26-50 | 51-100 | >100 |  | Foot Controls |  |  |  |  |
| Repetitive |  |  |  |  |
| Lift |  |  |  |  |  |  | Balance |  |  |  |  |
| Carry |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  | **Ability to be Exposed to Environmental Conditions:** | **Hours Per Day** |
| **Other Restrictions:** |  |  |  |  | 0-1 | 1-3 | 3-6 | 6-8 |
|  |  |  |  |  |  |  | Unprotected Height |  |  |  |  |
|  |  |  |  |  |  |  | Moving Machines |  |  |  |  |
|  |  |  |  |  |  |  | Dust/Fumes/Gases |  |  |  |  |
|  |  |  |  |  |  |  | Changes in Temperature/Humidity |  |  |  |  |

 |
| **Health Care Provider:** |
| Physician Signature | Physician Printed Name | Telephone Number |
|  |  |  |
| Address | Fax Number |
|       |  |

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| --- |
| **Claim Information:**  |
| Employee Name | Personnel Number | Date of Injury | Agency |
|       |       |       |       |
| **Restrictions:** Complete **only** if there are **agency-specific restrictions**, using an 8-hour day. |

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| **Ability to****Work Around:** | **Hours Per Day** |  | **Ability to Operate a** **Motor Vehicle:** | **Hours Per Day** |
| 0-1 | 1-3 | 3-6 | 6-8 |  | 0-1 | 1-3 | 3-6 | 6-8 |
| Shellac/Varnish |  |  |  |  |  | Car |  |  |  |  |
| Sawdust |  |  |  |  |  | Small Truck |  |  |  |  |
| Paint Thinner |  |  |  |  |  | Large Truck |  |  |  |  |
| Chemicals |  |  |  |  |  | Auto Transmission |  |  |  |  |
| Cleaners |  |  |  |  |  | Standard Transmission |  |  |  |  |
|  |  |  |  |  |  | Heavy Equipment |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Ability to Work****With:** | **Hours Per Day** |  | **Ability to Use a Weapon:** | **Yes** | **No** |
| 0-1 | 1-3 | 3-6 | 6-8 |  | Psychologically Able |  |  |
| Inmates |  |  |  |  |  | Physically Able |  |  |
| Patients |  |  |  |  |  | Mentally Able |  |  |
| Residents |  |  |  |  |  |  |  |  |
| Customers |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  | **Ability to xxx:** | **Hours Per Day** |
|  |  |  |  |  |  | 0-1 | 1-3 | 3-6 | 6-8 |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
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**Comments or other restrictions:** |
| **Health Care Provider:** |
| Physician Signature | Physician Printed Name | Telephone Number |
|  |  |  |
| Address | Fax Number |
|       |  |