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 14 DAYS OF THE ISSUANCE OF AN "AGREEMENT AS TO COMPENSATION" PAYABLE TO AN EMPLOYEE FOR ANY PERIOD OF TOTAL DISABILITY, THE EMPLOYER SHALL PROVIDE THIS FORM TO THE HEALTH CARE PROVIDER/PHYSICIAN MOST RESPONSIBLE FOR THE TREATMENT OF THE EMPLOYEE'S WORK-RELATED INJURY, AND TO THE EMPLOYER'S INSURANCE CARRIER, IF APPLICABLE. THE INSURANCE CARRIER FOR AN INSURED EMPLOYER SHALL SEND TO SUCH EMPLOYER THE AFOREMENTIONED REPORT FOR COMPLETION, AND SHALL BE INDEPENDENTLY RESPONSIBLE FOR PROVIDING A COMPLETED REPORT OF MODIFIED DUTY JOBS TO THE HEALTH CARE PROVIDER/PHYSICIAN, 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 (Circle)

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 of such form.

EMPLOYER FORM Revised 9/11/2013