Modified Duty: Carpenter

Employee Name: _____ **Date of Birth:** _____ **Claim Number:** _____

Employer: Check any/all "Available Tasks" boxes you can offer. Enter "Other" tasks you can offer.

Physician: Please check "yes" or "no" to those tasks that the injured worker is/is not capable of performing and sign below.

Employer Offer		Physician Response
Available Tasks		Release to Job Task?
☐	**Layout/design:** Review documents using tools such as framing squares, calipers and rulers. Involves sitting or standing, pinching, reaching and grasping.	◯ Yes ◯ No
☐	**Materials takeoff:** Review blueprints to determine lumber and other material requirements. Involves sitting or standing, pinching.	◯ Yes ◯ No
☐	**Measure materials:** Use tools to measure boards, timbers or plywood. Lifting up to 20 pounds. Involves standing, reaching, bending, pinching and gripping.	◯ Yes ◯ No
☐	**Order materials/ Answer phones:** Take incoming calls and messages and transfer to appropriate extensions. Place phone calls to order materials for jobs. Involves sitting, and possible computer use.	◯ Yes ◯ No
☐	**Verify trueness/Inspections:** Use plumb bob or level to verify structural trueness. Visual inspection of work done. Involves standing, squatting, kneeling and reaching.	◯ Yes ◯ No
☐	**Install insulation:** Apply shock-absorbing, sound-deadening material. Involves standing, kneeling, squatting, reaching, and stepladder use. Lift up to 5 lbs.	◯ Yes ◯ No
☐	**Install finish hardware:** Install various door handles and kick plates. Involves standing, squatting, sitting, kneeling and using hands. Lift less than 5 lbs.	◯ Yes ◯ No
☐	**File, Purge or Shred files**: Sort invoices/bills: Sort invoices, mail and reports, and place them in alphabetical or numerical order in appropriate file area. Clean out old files and dispose of unneeded invoices and correspondence. Lift up to 5 pounds. Involves sitting, standing, pinching.	◯ Yes ◯ No
☐	Enter Other Task	◯ Yes ◯ No
☐	Enter Other Task	◯ Yes ◯ No
☐	Enter Other Task	◯ Yes ◯ No

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Given the tasks you have checked off above, what number of hours are available for modified duty?

Regular_____hrs./day or Reduced _____hrs./day

Employee Name: _____ **Claim Number:** _____

Company Name: _____

Employer Contact: _____

Employer Phone: _____ **Employer Fax:** _____

Employer Email: _____

Physician comments on patient's ability to perform Job Tasks:

_____

_____

_____

_____

Physician Signature: _____ **Date:** _____