



## Modified Duty:

**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 capable of performing and sign below.

Employer Offer		Physician Response	
Available Tasks		Release to Job Task?	
		Yes	No



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: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_