Modified Duty: Manufacturing

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?
☐	**Counting Inventory:** Inventory supplies and products using clip board and/or code scanner. Inform employer of re-stocking needs. Sitting, standing, walking.	◯ Yes ◯ No
☐	**Operate Forklift and/or Electric Pallet Jack:** Move material as directed using devices. Seated driving, standing, walking.	◯ Yes ◯ No
☐	**Bench Work:** Inspecting, cleaning, counting, sorting, labeling and/or assembling small parts. Alternate sitting/standing. Lifting < 10 lbs.	◯ Yes ◯ No
☐	**Perform blow downs of equipment/parts:** Using pressurized air hose to blow away residue, dust, etc. from machinery, equipment, parts. Standing, walking, reaching either arm.	◯ Yes ◯ No
☐	**Light Grinding Work:** Using a grinder to smooth the surface of small parts. Sitting/Standing	◯ Yes ◯ No
☐	**Clean filters and magnets, grease parts, remove slag :** Standing, walking, occasional bending, lift< 10 lbs.	◯ Yes ◯ No
☐	**Light Soldering Work**: Sitting, standing.	◯ Yes ◯ No
☐	**Special Projects: Light work to be determined**	◯ Yes ◯ No
☐	**Review Safety Videos, Manuals and MSD Sheets:** Sitting	◯ Yes ◯ No
☐	**Train New Employees:** Provide verbal instruction about general manufacturing practices, equipment use, safety guidelines and orientation for new employees. Sitting and standing.	◯ Yes ◯ No
☐	**Clean-up Shop:** Use push broom to clear floors of debris, slip and fall hazards. Remove light trash to dumpster, organize and clean-up work areas. Standing, walking, lifting up to 10 lbs.	◯ 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:** _____