Ohio | Bureau of Workers' Compensation

Instructions for Completing the Physician's Report of Work Ability

This form provides important information about the injured worker's ability to work.

- The treating physician must submit this form each time he/she sees the worker unless the worker has been awarded permanent and total disability, or has been previously released to the worker's former position without restrictions.
- Please complete this form and provide a copy to the worker during the worker's office visit. Fax a copy to the appropriate managed care organization (MCO) or to the worker's employer if that employer is self-insured.
- This form or an equivalent physician-generated document may support a request for temporary total compensation. The equivalent document must contain, at a minimum, the data elements required on this form. If equivalent data elements have previously been submitted and remain the same, please indicate the name of the report that reflects the worker's current condition, e.g. 5/18/11 office note.
- You may attach additional medical documentation such as diagnostic test results and a treatment plan to this form.
- Failure to provide complete detailed information may delay or suspend compensation payments to the worker.

Instructions

Injured worker progress section: Please indicate how the worker is progressing. If a MEDCO-14 was previously completed and there are no changed circumstances to report, you may indicate such in the designated area. If there have been any changed circumstances, including changes in the period of temporary total disability or release with restrictions, you must provide updates by completing the appropriate areas indicated.

Work status section: If you do not have a copy of the worker's job description, BWC or the MCO can help secure one. "Former position of employment" means the job duties performed in the position the worker held when injured. Checking:

- The first box indicates that from a medical perspective the worker cannot return to the former position of employment (i.e. job duties required or performed in the position held when he/she was injured);
- The second box indicates the worker can return to employment with restrictions. This could include portions of the worker's previous duties or other duties not previously a part of his or her former position of employment;
- The third box indicates the worker can return to the former position of employment (i.e. job duties required or performed in the position held when he/she was injured.) The ability to return to the former position of employment means that the worker can perform the job duties with either the employer of record or with another employer.

Injured worker's capabilities section: BWC will use this information to help facilitate the worker's return to work. Complete this section as accurately and thoroughly as possible. The following definitions apply to the Lifting/carrying, Pushing/pulling, Activity and Driving sections and are percentages as they relate to an eight-hour workday:

- Never – 0 percent;
- Occasionally – 1 percent to 33 percent, four to six repetitions per hour;
- Frequently – 34 percent to 66 percent, six to 12 repetitions per hour;
- Continuously – 67 percent to 100 percent, greater than 12 repetitions per hour.

Only providers treating the worker for allowed psychological conditions should complete the portion labeled "Degree of functional impairment based on allowed psychological conditions only."

Disability period information section: Furnish the narrative description of the diagnosis(s), site/location, if applicable, and ICD code for the conditions being treated due to the work-related injury. For each condition, indicate whether or not the condition is causing the temporary total disability.

Clinical findings section: Provide medical rationale for the delay in the worker's recovery and the barriers to return to work.

Maximum medical improvement (MMI) section: Please provide the MMI date or explain why the worker has not reached MMI. Provide the proposed treatment plan including estimated duration.

Vocational rehabilitation section: If the worker is not a candidate for vocational rehabilitation, please explain and recommend actions to help the worker return to employment.

Treating physician's signature section: Sign and date this form. Your signature indicates you have answered the questions as truthfully and completely as possible.

For more information or assistance

Please contact your local BWC customer service office, or call 1-800-OHIOBWC. You can obtain BWC forms at ohiobwc.com, at all BWC customer service offices, or by calling 1-800-OHIOBWC and listening to the options to reach a BWC customer service representative.

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Physician's Report of Work Ability

Injured worker name	Claim number	Date of injury
Employer name and injured worker's position of employment at time of injury	Date of last exam or treatment	Next appointment date

Injured worker progress

1 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
If a MEDCO-14 was previously completed for this injured worker, are there any changes to the information provided in Section 2 through 7 to report at this time? ☐ Yes ☐ No *If yes, proceed to section 2. If no, proceed to section 8.*

Work status

2 Did you review a description of the injured worker's job duties as they existed on the date of injury (former position of employment)? Check all applicable boxes.

☐ Yes, I was provided a job description (verbal or written) by the ☐ Injured worker ☐ Employer ☐ MCO
☐ No, I have not been provided a job description.

Select one of the three options below.

☐ Injured worker is temporarily not released to any work, including the former position of employment from (date): ____/_____/_____ to ____/_____/_____. *Please complete required sections 4, 5, 6, 7 and 8.*

☐ Injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, from (date): ____/_____/_____ to ____/_____/_____. *Please complete required sections 3, 4, 5, 6, 7 and 8.*
The restrictions are: ☐ Permanent ☐ Temporary If temporary until what date? ____/_____/_____

☐ Injured worker is released to the former position of employment without restrictions as of (date): ____/_____/_____.
Is this date the day the injured worker actually returned to work? ☐ Yes ☐ No ☐ I don't know: *Proceed to section 8 and complete it.*

Injured worker's capabilities: Employer will use information in this section to evaluate available and appropriate work opportunities

3

How many total hours is this injured worker potentially able to work? _____ Hours in a day _____ Hours in a week

Upper extremities

The injured worker is able to perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker is able to perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both
The injured worker's dominant hand is: ☐ Left ☐ Right

Lower extremities

The injured worker is able to perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both

Medications

The injured worker is able to safely perform work duties which, if applicable, may include operating heavy machinery or driving while taking prescribed medications: ☐ Yes ☐ No
If no, what are the potential side effects: ☐ Dizziness ☐ Drowsiness ☐ Impaired ability ☐ Other, please explain

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously

Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C	Activity	N	O	F	C	Activity	N	O	F	C
0 – 10 lbs.					13 to 25 lbs.					Bend					Reach above shoulder				
11 – 20 lbs.					26 to 40 lbs.					Squat					Type/keyboard				
21 – 40 lbs.					41 to 60 lbs.					Kneel					**Driving**				
41 – 60 lbs.					61 to 100 lbs.					Twist/turn					Automatic				
61 – 100 lbs.					100 + lbs.					Climb					Standard shift				

In an eight-hour workday, how many total hours is the injured worker potentially able to work?

Sit: ___ hours ☐ Continuously ☐ With break | **Walk:** ___ hours ☐ Continuously ☐ With break | **Stand:** ___ hours ☐ Continuously ☐ With break

Degree of functional impairment based on allowed psychological conditions only, if applicable.

	None	Mild	Moderate	Marked	Extreme
Activities of daily living: Self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities and occupational functioning	☐	☐	☐	☐	☐
Social functioning: Capacity to interact and communicate effectively and get along with others	☐	☐	☐	☐	☐
Concentration, persistence and pace: Ability to sustain focused attention long enough to complete tasks commonly found in the workplace	☐	☐	☐	☐	☐
Adaptation: Ability to appropriately react to stressful circumstances, including the workplace; includes attendance, making decisions, scheduling or completing tasks and interacting with supervisors and co-workers	☐	☐	☐	☐	☐

Injured worker name	Claim number	Date of injury

Disability period information (all fields required, including site/location if applicable)

4 Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and ICD code for the conditions being treated due to the work-related injury. Please indicate if the condition is causing temporary total disability **(all fields required, including site/location, if applicable).**

Narrative description of the work-related condition	Site/Location If applicable	ICD code	Is the condition causing temporary total disability?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

List all other conditions being treated (attach additional sheet if necessary).

Clinical findings

5 Provide your clinical and objective findings supporting your medical opinion outlined on this form. List any barriers to return to work and any reason for the injured worker's delay in recovery.

Maximum medical improvement (MMI)

6 MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability in spite of continuing medical or rehabilitative procedures. An injured worker may need supportive treatment to maintain this level of function. Note: periodic medical treatment may still be requested and provided.
Has the work-related injury(s) or occupational disease reached MMI based on the definition above? ☐ Yes ☐ No
If yes, give MMI date: _____/_____/_____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Vocational rehabilitation

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions, and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work? ☐ Yes ☐ No If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

8 I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Treating physician's name (please print legibly)			Physician PEACH number	
Address	City	State	Nine-digit ZIP code	Telephone number – –
Treating physician signature			Date	Fax number – –