DELAWARE WORKERS' COMPENSATION
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

DATE:_____

EMPLOYER:_____ EMPLOYEE:_____

IS MODIFIED DUTY AVAILABLE: _____ Yes _____ No EMPLOYER FAX #:_____

IF AVAILABLE, FOR WHAT PERIOD OF TIME: _____ Weeks _____ Indefinite

JOB TITLE: _____

JOB DESCRIPTION:_____

ENVIRONMENT/WORKING CONDITIONS (e.g., Temperature):_____

ADDITIONAL INFORMATION:

Hrs. per day job available: (circle minimum and maximum): 8 6 4 2 0

Work Postures: Maximum required hours for above work day (circle one in each category below):

Sitting:	0	1	2	3	4	5	6	7	8
Standing:	0	1	2	3	4	5	6	7	8
Walking**;**	0	1	2	3	4	5	6	7	8
Driving:	0	1	2	3	4	5	6	7	8

Comments:_____

Lift/Carry & Push/Pull: D.O.T. Classification of Work		Lift/Carry check one:	Push/Pull check one:
Sedentary	10 lbs max: occasionally carry small objects	( )	( )
Light	up to 20 lbs max: frequently lift/carry up to 10 lbs	( )	( )
Medium	up to 50 lbs max. frequently lift/carry up to 25 lbs	( )	( )
Heavy	up to 100 lbs max. frequently lift/carry up to 50 lbs	( )	( )
Very Heavy	over 100 lbs occasionally; frequently lift/carry over 50 lbs	( )	( )

Based on the total hrs. per day job is available, this job requires (circle one in each category below):

Bending:	0%	25%	50%	75%	100%
Turn/Twist:	0%	25%	50%	75%	100%
Kneeling:	0%	25%	50%	75%	100%
Squatting:	0%	25%	50%	75%	100%
Crawling,	0%	25%	50%	75%	100%
Climbing:	0%	25%	50%	75%	100%
Repeated arm motions:	0%	25%	50%	75%	100%
Reaching up above shoulder:	0%	25%	50%	75%	100%
Foot controls:	0%	25%	50%	75%	100%

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)_____ Certification No.:_____

(Rev: 9/11/07)

EMPLOYER FORM