Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

@ D.O.B 8/3/79

Injured worker name	Claim number	Date of injury
Jeremy Davis	16-814288	4-11-16
Employer name and injured worker's position of employment at time of injury	**Date of last exam or treatment**	**Next appointment date**
EMP Staffing Solutions	4-18-16	5-9-16

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

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.

2 ☒ Injured worker is temporarily not released to any work, including the former position of employment from (date): 4/18/16 to 5/2/16. *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

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

3 **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	☐	☐	☐	☐	☐

WorkStar Health Services Rec'd 4/19/2016 10:36:23

Medical Repository, 4/19/2016 10:22:52 AM [Eastern Daylight Time]

@ D.O.B 8/3/79

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Jeremy Davis	16-814288	4-11-16

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?
Open fracture of maxilla, sequela		S02.40XS	☒ Yes ☐ No
Open fracture of ramus of mandible, sequela		S02.64XS	☒ 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.

See Enclosed Office Note

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

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.

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Treating physician's name (please print legibly)				BWC # Physician PEACH number
Adam D. Cash M.D.				279783015-00
Address	City	State	Nine-digit ZIP code	Telephone number
1950 Niles-Cortland Rd. NE Suite 9	Warren	OH	44484	330-856-2545
Treating physician signature			Date	Fax number
			4/19/16	330-856-2542

Workstar Health Services 4/19/2016 10:56:23

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