PROTECTIVE INSURANCE | P.O. Box 2865, Clinton, IA 52733-9924
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Work Restriction Sheet

Adjuster: Phone/Fax:
Case Manager:_____ Phone/Fax:_____

Employee Name:_____ DOB: _____ Claim #: _____ Phone: _____

Physician: _____ Phone/Fax: _____ Date: _____

1. Current Clinical Status

A. Working Diagnosis: _____ DOI: _____

B. Is condition felt to be work-related? q Yes q No q Uncertain

C. In-Office Procedures:_____

D. Follow-up Recommendation:_____ Days_____ Weeks_____ Months_____ Next Appointment:_____

E. Reached MMI q Yes q No

2. Tests Recommended:

A. Type of tests: _____

B. Brief Rationale:_____

_____

_____

C. Follow-up after test completion:_____Days

3. Treatment Recommended:

A. Type of Treatment: q OT q PT q Surgery

B. Rationale: Conservative Management q
Failure to Improve q
Post-Operative Routine q

C. Frequency_____ Duration_____

4. Surgery Recommended:

_____

_____

5. Physical Limitations for Work Activities

A. Off work unil_____

B. Light duty from _____ to _____(see chart)

If no light duty, then off work

Return to Full Duty_____

C. Part-time / Full activity_____Hrs./Day

D. Employer notified q Yes q No

q	**Lifting/Carrying- Maximum lbs.**	**100-75**	**74-50**	**49-35**	**34-20**	**19-11**	**10-0**
	frequently	q	q	q	q	q	q
	occasionally	q	q	q	q	q	q
q	**Movement Limitations**	**Bend**	**Twist**	**Squat**	**Kneel**	**Climb**	**Drive**
	frequently (34-66%)	q	q	q	q	q	q
	occasionally (0-33%)	q	q	q	q	q	q
	not at all	q	q	q	q	q	q

q **Restricted Use of Hand/Arm** Right q Left q Both q

	Grip	**Pinch**	**Push/Pull**	**Reach Above Shoulder**
frequently (34-66%)	q	q	q	q
occasionally (0-33%)	q	q	q	q
not at all	q	q	q	q

q **No Reaching Above Chest Level**

q **Restricted Standing/Walking** _____ Hrs. per Day q **Restricted Sitting** _____Hrs. per Day

q **No Work in a Cold Environment**

q **No Knife and No Hook**

q **Temperature Restrictions:** (explain) _____

q **Sterlization/Contamination Restrictions:** (explain) _____

q **Other** _____

_____

M.D. Signature_____