RISK MANAGEMENT DIVISION
DOCTOR VISIT/MODIFIED WORK ASSIGNMENT

EMPLOYEE IS TO RETURN THIS COMPLETED FORM TO HIS/HER EMPLOYER AT THE CONCLUSION OF EACH AND EVERY DOCTOR VISIT

DATE ______________________ EMPLOYER ______________________________

DOCTOR ______________________ SOCIAL SECURITY # _____________________

____

__________________________is a State of New Mexico, __________________Department employee. An alleged on the job injury was reported by this employee on ________________________which may require treatment, as you determine. Please complete the data below so that a claim may be processed by the Risk Management Division.

Thank you for your cooperation in this matter.

________________________	____________________	______________
Supervisor	Agency/Division	Phone

1. Diagnosis ____

____

2. Was employee released today? Yes _______ No ________
3. X-ray(s)? Today: Yes ________ No ________
4. Medication prescribed? Yes ________ No ________ Continued _________
5. Can employee return to normal duty at this time? Yes _______ No ________
6. If Yes, has the employee reached MMI? Yes _______ No ________
7. If "No", can employee return to work on a limited/restricted basis? Yes ________ No _______
8. If "Yes" to #6, what restrictions?

_________ NO REACHING ABOVE SHOULDER.
_________ NO CLIMBING OF STAIRS OR LADDERS.
________ NO LIFTING OVER _______ LBS.
_________NO KNEELING/SQUATING.
__________NO PUSHING OR PULLING
__________NO OPERATION OF MACHINERY
__________ NO REPETITIVE WAIST BENDING.
__________ LIMITED/NO USE OF
____

OTHER____

How long will restrictions last? Until next visit __________ Other date _________________

9. When is next visit scheduled? _______________________

10. Other Comments ____

____

ATTENDING DOCTOR _______________________________________

RMDWC1.RFM(10/93)

MODIFIED WORK ASSIGNMENT

I, ____ have read the restrictions detailed below and have discussed said restrictions with my supervisor/employer,

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I understand the nature of the restrictions and further understand that any violations of said restrictions may cause aggravation or further, injury. I also understand and will comply with the rules or orders noted below as a condition of employment on a modified work assignment.

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_____________________________________ _______________________
Employees Signature Date

_____________________________________ _______________________
Immediate Supervisor Date

RMDWC2:FRM(10/93)