# Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form

**BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3.**

**NOTE: Physicians shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.**

Information preceded by an asterisk (✱) is to be completed only for the initial visit.

| | | FOR INSURER USE ONLY |
|---|---|---|
| **1.** ✱Insurer Name: | **2.** Visit / 30-Calendar Day Review Date: | |
| **3.** Patient's Name: | **4.** Patient's Social Security No.: | **5.** ✱Date of Birth: |
| **6.** ✱Patient's Occupation | **7.** ✱Name of Employer | **8.** Date of Reported Injury: |

**The fact that a patient has been referred to a physician by an insurer for a reported work injury does not mean the identified clinical dysfunction is causally related to the reported work incident. Further, the fact that a physician has determined the initial injury to be work related does not necessarily mean that additional patient complaints or secondary symptoms are work related.**

## Section I Clinical Assessment

**9. a) ☐ Condition for which treatment is sought is not related to the work injury.**

**b) ☐ No Change in Clinical Assessment (Items 10 - 13) since last report submitted. (Go to Section II)**

**10. Objective Relevant Medical Findings**: Pain or abnormal anatomical findings, in the absence of objective relevant medical findings shall not be an indicator of injury and/or illness and are not compensable. Therefore, the physician shall apply requirements pursuant to ss.440.09(1) and 440.13(16)(a) F.S. to dates of accident on or after 10/1/2003. (See instructions for dates of accident prior to 10/1/2003)

Has the patient been determined to have objective relevant medical findings? **a)** ☐ No **b)** ☐ Yes **c)** If yes, specify below.

____________________________________________________________

____________________________________________________________

**11.** Specify diagnosis related to findings identified in 10c: ________________________________

**12. Major Contributing Cause**: When there is more than one contributing cause, the reported work related injury must contribute more than 50% to the present condition and be based on the findings in 10c. The Physician shall apply language found in ss. 440.09(1) and 440.13(16)(a), F.S. to dates of accident on or after 10/1/2003. (See instructions for dates of accident prior to 10/1/2003.)

**a)** Have you determined that there is a pre-existing condition contributing to the current medical disorder? **$a_1$)** ☐ Yes **$a_2$)** ☐ No

**b)** Do the objective relevant medical findings identified in Item 10c represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition? **$b_1$)** ☐ Yes **$b_2$)** ☐ No If yes, check: **$b_3$)** ☐ exacerbation or **$b_4$)** ☐ aggravation

**c)** Are there other relevant co-morbidities that will need to be considered in evaluating or managing this case? **$c_1$)** ☐ Yes **$c_2$)** ☐ No

**Note:** if either 12 $a_1$) - $c_1$) are checked, specific details must be documented in your medical records.

**d)** Given your responses to Items 10 – 12a-c, above, is the injury in question the major contributing cause for:

- the reported medical condition? **$d_1$)** ☐ Yes **$d_2$)** ☐ No
- the treatment recommended (management/treatment plan)? **$d_3$)** ☐ Yes **$d_4$)** ☐ No
- the functional limitations and restrictions determined? **$d_5$)** ☐ Yes **$d_6$)** ☐ No

**13. Patient Classification:** For this visit, the physician must identify the appropriate level that accurately represents the patient's status based upon objective relevant medical findings. Indicate the most appropriate level listed below. (See instructions)

**a)** ☐ Level I: Well defined, work-related medical condition associated with specific physiologic dysfunction(s); little or no discordance between physical findings and the medical complaint.

**b)** ☐ Level II: Defined by the presence of systemic abnormalities, i.e., deficits in strength, flexibility, endurance, motor control; may or may not have well-defined specific physiologic dysfunction(s).

**c)** ☐ Level III: Defined by the presence of significant, associated psychological or vocational issues; have systemic deficits present (see Level II); may or may not have specific physiologic dysfunction(s).

**d)** ☐ Patient status undetermined at this time for the following reason(s) ____________________________

____________________________________________________________

## Section II Management / Treatment Plan

**14. ☐ No Change in Management/Treatment Plan (Items 15 - 16) since last report submitted. (Go to Section III)**

**15.** Based upon the preceding Clinical Assessment (Items 10 – 13), applying provisions under ss.440.09 and 440.13, F.S. and other applicable statutory sections of Chapter 440, F.S., the following treatment(s) is/are deemed necessary and proposed for authorization by the insurer:

**a)** ☐ No treatment indicated at this time.

**b)** ☐ Consultation with/referral to Specialist/Practitioner: Physician completing this form requests to continue to serve as the principal treating physician for the reported work related injury, but requests a consultation with/referral to a (specify specialty and provide rationale): ________________________________

**c)** ☐ Transfer of care to a Specialist: The Physician completing this form will not remain the principal treating physician for the reported work related injury and hereby recommends authorization for transfer of care to a (specify specialty and provide rationale):

____________________________________________________________

## Section II Management / Treatment Plan

**d)** ☐ Diagnostic Testing (specify): ______

**e)** ☐ Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration in the section below.

**1.** ☐ Physical Therapy, Chiropractic, Osteopathic or comparable treatment
**2.** ☐ Physical Reconditioning (Level II Patient Classification)
**3.** ☐ Interdisciplinary Rehabilitation Program, Commission on Accreditation of Rehabilitation Facilities (CARF)/Joint Commission on Accreditation of Healthcare Organizations (JCAHO), e.g. work hardening, chronic pain (Level III Pt. Classification)

Please specify details (timeframes and other parameters): ______

______

**f)** ☐ Pharmaceutical(s) (specify): ______

**g)** ☐ Other – Medical Procedure(s) (specify): ______

**h)** ☐ Surgical Intervention (please specify procedure(s)):

**1.** ☐ Minor Surgery in Physician's Office: ______
**2.** ☐ Injectables (pain management, e.g. nerve block, epidural): ______
**3.** ☐ Operating Room Surgical Procedure(s) (Hospitals, Ambulatory Surgical Centers): ______

**16. MMI/PIR a)** MMI: Yes, MMI Date: ______ **b)** PIR % (body as a whole): ______ **c)** ☐ MMI: No

Guide used: ☐AMA Guide ☐ Minnesota Disability Schedule ☐ 1993 FL Impairment Guide ☐ 1996 FL Uniform PIR Schedule

**d)** Anticipated MMI date: ______ **e)** ☐ Anticipated MMI date cannot be determined at this time

**f)** Is a residual clinical dysfunction or residual functional loss anticipated for the work related injury? **$f_1$)** ☐ Yes **$f_2$)** ☐ No

**17. Next Scheduled Appointment: a)** Date ______ **b)** Time ______ **c)** ☐ Not Applicable

## Section III Determination of Functional Limitations and Restrictions

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status **related** to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

**18.** ☐ No functional limitations identified or restrictions prescribed at this time.

**19.** ☐ The injured worker may return to work so long as he/she adheres to the functional limitations and restrictions identified below.

**20.** ☐ The injured worker's functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform work, even at a sedentary level, at this time (e.g. hospitalization, strict bed rest, cognitive impairment, infection/contagion).

From the list below (including any 'Other' functional activities) identify **ONLY** those functional activities for the patient that has specific limitations and restrictions. Use additional sheet if needed.

| | | | | | |
|---|---|---|---|---|---|
| ☐ Stand | ☐ Stoop | ☐ Push | ☐ Hand dexterity | ☐ Driving/Operating Heavy Equipment | ☐ Job specific task(s) |
| ☐ Sit | ☐ Bend | ☐ Pull | ☐ Reach – overhead | ☐ Environmental considerations: heat, | |
| ☐ Twist | ☐ Walk | ☐ Carry | ☐ Lift - waist to overhead | cold, working at heights, vibration | NOTE: When applicable specify |
| ☐ Kneel | ☐ Crawl | ☐ Grasp | ☐ Lift - floor to waist | ☐ Skin contact/exposure | joint and/or body part. |
| ☐ Climbing | ☐ Vision | ☐ Auditory | ☐ Sensory | ☐ Cognitive (organic) | |

☐ Other: ______ ☐ Other: ______ ☐ Other: ______

| **FUNCTIONAL ACTIVITY** | **PARAMETERS/DETAILS** (LOAD AMOUNTS, FREQUENCY & DURATION, RANGE OF MOTION & POSITIONAL BOUNDARIES) |
|---|---|
| $a_1$) ______ | $a_2$) ______ |
| $b_1$) ______ | $b_2$) ______ |
| $c_1$) ______ | $c_2$) ______ |

**NOTE**: Any functional limitations or restrictions that have been assigned above **apply to both on and off the job activities**, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date. **If MMI / PIR has been assigned in Item 16, specify those functional limitations and restrictions (identified in Item 19) which are permanent. (See Instructions)**

"As the Physician, I hereby attest that all responses herein have been made to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient. I certify to any MMI / PIR information provided in this form." **Date:** ______

**Physician Signature:** ______ **Physician DOH License:** ______

Physician Name: ______ Physician Specialty: ______
*(print name)*

**If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:**

"I hereby attest that all responses herein relating to services I rendered have been made to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

**Provider Signature:** ______ **Provider DOH License:** ______

Provider Name: ______ **Date:** ______
*(print name)*

# FORM DFS-F5-DWC-25

# COMPLETION/SUBMISSION INSTRUCTIONS

## GENERAL INFORMATION

The Form DFS-F5-DWC-25 has been adopted by the Florida Division of Workers' Compensation in Rule 69L-7.602, F.A.C., as the required reporting form for physicians to recommend and report to insurers/employers the medical treatment and medical status of the injured employee, including the establishment of the date of maximum medical improvement and assignment of permanent impairment rating, when applicable. The Form DFS-F5-DWC-25 shall be submitted by the provider to the insurer, and to the employer upon request, upon the occurrence of any actionable event (change in treatment plan, regime, therapies, prescriptions, or functional limitations or restrictions), and following the injured employee achieving maximum medical improvement, in accordance with the conditions and timeframes established in this rule. In instances where the form is submitted without the occurrence of any actionable event, receipt of new information or patient re-examination, it is anticipated that the provider will submit the form reflecting an unchanged patient status.

Insurers/employers and providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of the injured employee's medical treatment/status. Any other reporting forms may not be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

Accurate completion of the Form DFS-D5-DWC-25 and the terms used herein do not create any access to medical services or alter any conditions associated with the provision or reimbursement of medical services other than as allowed in Section 440.13, F.S.

No reimbursement shall be made for completion of the DFS-D5-DWC-25 except for provision of health care provider services that include establishment of the date of maximum medical improvement and assignment of an impairment rating as specified in Rule 69L-7.020, F.A.C.

For dates of accident October 1, 2003 or after, it is the physician's primary responsibility in treating the injured employee to apply provisions of ss.440.09 and 440.13, F.S. when:

a. Evaluating an injury or illness,
b. Ordering, prescribing or rendering remedial treatment care or attendance, and
c. Assigning functional limitations or restrictions.

## COMPLETION REQUIREMENTS

**WHO** must complete the Form DFS-F5-DWC-25:

- All physicians (including physician assistants and ARNPs under supervision of a physician) who provide direct billable services immediately following the reported work related injury, regardless of location.
- Physicians providing preliminary treatment, care or attendance in the emergency room of a hospital licensed under Chapter 395, F.S. shall be required to accurately complete Items 1-8, 10, 11, 18, 19 and signature.
- All principal physicians or physicians accepting consults/referrals or transfers of care, including physician assistants and ARNPs under supervision of a physician, who provide ongoing treatment, care or independent medical examinations.

## COMPLETION GUIDELINES

Physicians completing the Form DFS-F5-DWC-25 must apply the following guidelines:

- Accurate completion and submission of the Form DFS-F5-DWC-25 does not fulfill the provider requirement to obtain prior insurer approval and authorization for referrals, consultations, treatment plans, and/or other medically necessary services.
- Accurate completion and submission of the Form DFS-F5-DWC-25 is in addition to medical billing forms required pursuant to this rule.
- The Form DFS-F5-DWC-25 does not replace physician notes, medical records or required medical billing reports.
- Physician notes, medical records, or other relevant diagnostic tests and evaluations must be consistent with all information submitted on the Form DFS-F5-DWC-25, and shall document additional details of the medical services rendered to the injured employee.

- A copy of the Form DFS-F5-DWC-25 shall become part of the permanent medical records of the injured employee retained by the physician.
- Physicians shall provide a copy of the accurately completed Form DFS-F5-DWC-25 to the employer, upon request.

## SUBMISSION REQUIREMENTS

Physicians may submit the accurately completed Form DFS-F5-DWC-25 electronically or via facsimile contingent upon insurer agreement.

**WHEN** the Form DFS-F5-DWC-25 must be submitted:

Submission requirements for all physicians certifying MMI and PIR are itemized in 'Section II' instructions under the heading *Maximum Medical Improvement/Permanent Impairment Rating*.

The Form DFS-F5-DWC-25 shall be submitted to the insurer, and to the employer upon request, as follows:

All Physicians who provide the first treatment immediately after the reported work related injury shall submit the accurately completed Form DFS-F5-DWC-25 to the insurer, and to the employer, immediately but no later than three (3) business days after the visit for the claim for medical or surgical treatment to be valid, pursuant to s.440.13(4)(a), F.S.

**Principal Physician**

- The physician shall accurately complete the Form DFS-F5-DWC-25 after each and every subsequent visit, or at a minimum of every 30 days, even when the physician receives no new information since the last visit or does not re-examine the patient. In instances where the form is submitted without the occurrence of any actionable event, receipt of new information or patient re-examination, it is anticipated that the provider will submit the form reflecting an unchanged patient status. The accurately completed Form DFS-F5-DWC-25 shall be submitted to the insurer, and to the employer upon request, by close of the next business day following each subsequent visit or a maximum of 30 days from the date of the prior Form DFS-F5-DWC-25 submission.

- The **physician accepting the transfer of care** from the principal physician shall accurately complete and submit the Form DFS-F5-DWC-25 to the insurer, and to the employer upon request, by the close business on the next business day following the first visit. The accurately completed Form DFS-F5-DWC-25 shall be submitted to the insurer, and to the employer upon request, by close of the next business day following each subsequent visit or a maximum of 30 days from the date of the prior Form DFS-F5-DWC-25 submission. In instances where the form is submitted without the occurrence of any actionable event, receipt of new information or patient re-examination, it is anticipated that the provider will submit the form reflecting an unchanged patient status.

**Consulting / Referral Physician**

- The consulting/referral physician shall accurately complete the Form DFS-F5-DWC-25 and submit to the insurer, and to the employer upon request, by the close of business on the next business day following the visit. In instances where the form is submitted without the occurrence of any actionable event, receipt of new information or patient re-examination, it is anticipated that the provider will submit the form reflecting an unchanged patient status. If the consulting/referral physician evaluates and is authorized, by the insurer, to treat a specific disorder or injury he/she shall submit the accurately completed Form DFS-F5-DWC-25 to the insurer, and to the employer upon request, by the close of business on the next business day following each subsequent visit or a maximum of 30 days from the date of the prior Form DFS-F5-DWC-25 submission. The consulting/referral physician must also submit the Form DFS-F5-DWC-25 to the principal physician if directed to do so by the insurer.

## COMPLETION INSTRUCTIONS

Statutory changes effective 10/1/2003 do not apply to dates of accidents before that date. Therefore, instructions for the item numbers listed below will indicate whether the new statutory language does or does not apply.

If additional space is required to complete an item on the form, please attach an additional sheet(s) containing the response. The additional pages must contain the injured employee's name, social security number or division-assigned number, date of reported injury, and the item number to which the response applies.

## DEMOGRAPHIC INFORMATION

- Items 1 through 8 – All fields must be accurately completed on the initial Form DFS-F5-DWC-25.
- Items 2, 3, 4, and 8 – Required to be accurately completed on each subsequent Form DFS-F5-DWC-25.

## SECTION I – CLINICAL ASSESSMENT

- Item 9 a – Applies to all dates of accident. If checked, sign and submit the form.
- Item 9 b – Applies to all dates of accident. Check only if there is no change in your prior responses to Items 10 through 13. If checked, proceed to Section II.
- If neither 'a' or 'b' is checked, proceed to 'Objective Relevant Medical Findings'.

**Objective Relevant Medical Findings:** Pursuant to s.440.09(1), F.S., pain or other subjective complaints alone, in the absence of objective relevant medical findings, are not compensable. Further, pursuant to s.440.13(16)(a), F.S., abnormal anatomical findings alone, in the absence of objective relevant medical findings, shall not be an indicator of an injury or illness, a justification for the provision of remedial medical care, the assignment of restrictions, or a foundation for limitations. Objective relevant medical findings are those objective findings that correlate to the subjective complaints of the injured employee and are confirmed by the physical examination findings or diagnostic testing.

- Item 10 – The narrative above applies to dates of accident 10/1/2003 forward. For dates of accident before 10/1/2003, reference to the statutory language "pain or other subjective complaints alone, in the absence of objective relevant medical findings" does not apply.

  10 a-b – Either 'a' or 'b' must be checked, regardless of date of accident.

  10 c – Must be accurately completed when 'b' is checked.
- Item 11 – Must be accurately completed, regardless of date of accident.

**Major Contributing Cause:** Pursuant to s.440.09(1), F.S., when there is more than one cause contributing to a medical disorder, including pre-existing conditions, the work injury must be the major contributing cause for the identified disorder to be compensable. Major contributing cause means the cause that is more than 50% responsible for the injury compared to all other causes combined. Major contributing cause must be demonstrated by medical evidence only.

- Item 12 – The narrative above applies to dates of accident 10/1/2003 forward. For dates of accident before 10/1/2003, the reference to statutory language "major contributing cause which is more than 50% responsible for the injury" does not apply.

  12 a – Either '$a_1$'or '$a_2$' must be checked, regardless of date of accident.

  12 b – Either '$b_1$'or '$b_2$' must be checked, regardless of date of accident.

  If '$b_1$' is checked, either '$b_3$'or '$b_4$'must be checked.

  Check '$b_3$' when patient demonstrates a temporary worsening of the condition resulting from the work related injury.

  Check '$b_4$' when patient experiences a progressive increase in the severity of the condition resulting from the work related injury.

  12 c – Either '$c_1$'or '$c_2$' must be checked, regardless of date of accident.

  12 d – Either '$d_1$'or '$d_2$' must be checked, regardless of date of accident, and
  Either '$d_3$'or '$d_4$' must be checked, regardless of date of accident, and
  Either '$d_5$'or '$d_6$' must be checked, regardless of date of accident.

**Patient Classification Levels** are designed to promote accountability and responsible medical claims handling practices which facilitate the authorization process and the provision of medically necessary and reasonably prudent care by:

a. conveying to insurers the complexity of services that may be required for optimal clinical management;

b. correlating intervention(s) to specified problem(s) and facilitating aspects of additional decision making by insurers; and

c. upgrading or removing functional limitations or restrictions and returning the injured employee to work as early as appropriate.

The physician shall correlate the documented physiologic or clinical problem identified on initial examination or reassessment with the appropriate patient classification level and shall provide the insurer with the type, intensity and duration of evaluation and management services or recommended treatment plans (including consultations, referrals, diagnostic testing, physical medicine regimens, surgical, pharmaceutical or other medical interventions) for which authorization is required.

- Item 13 – Applies to all dates of accident.
  - 13 a-d – At least one box must be checked. If 'd' is checked, a written entry is required in 'reason(s)'.

**SECTION II MANAGEMENT / TREATMENT PLAN**

- Item 14 – Check only if there is no change in your prior responses to Items 15 and 16.
  If checked, proceed to Section III.
- Item 15 – Applies to all dates of accident. At least one box must be checked. All appropriate boxes shall be checked based on physician recommendation(s), regardless of date of accident.
  - 15 a – Check only if no additional treatment is anticipated.
  - 15 b – Check only for consultation/referral. If checked, only specify the consulting/referral physician's specialty and not a particular physician's name.
  - 15 c – If checked, only specify the physician's specialty and not a particular physician's name.
  - 15 d – If checked, itemize diagnostic test(s) needed.
  - 15 e – If checked, must check '1', '2' or '3' and a written entry is required in "Specific Details"
  - 15 f – If checked, must specify drugs or pharmaceutical products.
  - 15 g – If checked, must list specific procedures.
  - 15 h – If checked, must check '1', '2' or '3' and a written entry is required in details.

**Maximum Medical Improvement/ Permanent Impairment Rating (Section II, Item 16.)**

Pursuant to Section 440.15(3)(d)1, F.S., which applies to all dates of accident, a physician shall establish the date of maximum medical improvement, including determination of any physical limitations, and shall assign a permanent impairment rating for the work injury.

All physicians involved in the care of any injured employee for a specific work related injury shall accurately complete 16 a. and b. on the Form DFS-F5-DWC-25, when applicable. When multiple physicians are involved, physicians certifying MMI /PIR, shall accurately complete Items 16 a. and b. on the Form DFS-F5-DWC-25, when applicable. Each physician shall independently send the Form DFS-F5-DWC-25 to the injured employee within three business days following the visit, and to the principal treating physician, the insurer and the employer upon request, by close of the business day following the visit.

If a non-treating physician certifies MMI/PIR in Item 16, that physician must report on the DFS-F5-DWC-25 such determinations to the treating physician, the insurer and the employee, within ten calendar days of the visit.

The principal treating physician shall report the date of maximum medical improvement, including any physical limitations, and permanent impairment rating on the Form DFS-F5-DWC-25 and provide a copy to the injured employee within three business days following the visit, the insurer, and to the employer upon request by close of the next business day following the visit.

- Item 16 – Applies to all dates of accident. Item 16 shall be accurately completed to indicate if the physician:
  1) can or cannot anticipate the date the patient will achieve maximum medical improvement (MMI) and/or
  2) can assign a date of maximum medical improvement and
  3) can assign a permanent impairment rating

  16 a - c – Either ‘a’ and ‘b’ must be accurately completed or ‘c’ checked.
  16 a – Enter the date the physician determines a maximum medical improvement date and complete 16 b. AND
  16 b – Enter the permanent impairment rating for the body as a whole (zero is a valid permanent impairment rating). If completed, go to 16 f., OR
  16 c – Check if patient has not achieved MMI. If checked, ‘$f_1$’ must be completed or ‘$f_2$ must be checked.
  16 d – Must enter date, when appropriate
  16 e – Check if physician is unable to anticipate a date the injured employee will achieve MMI.
  16 f – Either ‘$f_1$’or ‘$f_2$’ must be checked

  The Permanent Impairment Rating (PIR) Guides shown below are to be utilized by the physician to calculate the injured employee’s permanent impairment rating pursuant to Rule 69L-7.604, F.A.C. The physician shall check the box, in front of the appropriate guide listed on the form, and document in the medical records which guide was used to assign the permanent impairment rating.

  **For dates of accident:**

  | | |
  |---|---|
  | Prior to and through 6/30/90 | AMA Guide |
  | 7/1/90 through 10/31/92 | Minnesota Disability Schedules |
  | 11/1/92 through 1/6/97 | 1993 FL Impairment Guide |
  | 1/7/97 to present | 1996 FL Uniform Permanent Impairment Rating Schedule |

- Item 17 – Either ‘a’ AND ‘b’ must be accurately completed OR ‘c’ must be checked, regardless of date of accident.

## SECTION III – DETERMINATION OF FUNCTIONAL LIMITATIONS AND RESTRICTIONS

**Determination of functional limitations and restrictions under this section is intended to provide information to the employer/insurer to make a decision if the injured employee may physically return to work. If MMI/PIR has been assigned, the physician MUST indicate when functional limitation(s) or restriction(s) are permanent.**

- Item 18 – Applies to all dates of accident. Check box only if the injured employee has been identified as having no functional limitations and no work restrictions are prescribed at this visit. If checked, sign and submit the form.
- Item 19 – Applies to all dates of accident. Check box only if the injured employee may return to work with limitations and restrictions as identified. If checked, detailed written entry is required in spaces labeled ‘$a_1$’ through ‘$c_2$’.
- Item 20 – Applies to all dates of accident. Check box only if the injured employee cannot perform work even at a sedentary level. If checked, detailed written entry is required in spaces labeled ‘$a_1$’ through ‘$c_2$’.

**List _only_ functional limitation(s) and restriction(s), i.e. those activities, movements, postures/positions, or environments the injured employee should modify, and to what extent.**

- **Examples:**
  - Lifting floor to waist – no more than 40 lbs, 3-5 lifts per/hr, for the next 2 weeks.
  - Standing – no more than 30 min per bout separated by 5-10 minute breaks (sitting, lying, or self-stretching exercises) – permanent.
  - R shoulder flex or abduction – whether active or passive, no more than 90 deg. for next 3 days

- Squatting – avoid altogether, use sit, kneel or half-kneel instead.
- Wound contact – avoid contact with dirt, water, excessive heat/cold until next visit.
- Cognitive deficit – cannot follow written instructions; cannot perform multi-tasking activities; requires frequent supervision; cannot perform calculations

***Use an extra sheet if additional space is needed.***

**Note:** Limitations and restrictions will be applied as documented. If there are any ***global*** restrictions regarding the injured employees overall work schedule, please specify in the **parameters/details** section.

Sample items (for illustration purposes)

- no more than 4 hours per day for the next 3 weeks
- no more than 3 days per week until the next visit
- may only work during daylight hours - permanent
- no overtime or double shifts for the next 6 weeks

**Physician Signature**

- The Principal/Consulting/Referral Physician authorized to provide remedial care and treatment for the injured employee must accurately complete the 'date', 'signature', 'license number', 'printed name' and 'physician specialty' areas of this section on all Forms DFS-FS-DWC-25 prepared by the physician or under his/her direction.
- If any direct billable services for this visit were rendered by a provider other than a physician the non-physician licensed provider must accurately complete the 'signature', 'license number', 'printed name' and 'date' areas of this section. If only the Principal/Consulting/Referral Physician provided direct billable services, enter 'N/A' to indicate not applicable.