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,

_____

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.

_____

_____

_____

_____

_____

_____ _____

Employees Signature Date

_____ _____

Immediate Supervisor Date

RMDWC2:FRM(10/93)