



Physician's Return-to-Work & Voucher Report
FOR INJURIES OCCURRING ON OR AFTER 1/1/13 or injuries occurring on or after January 1, 2013

The Employee is P&S from all conditions and the injury has caused permanent partial disability

Employee Last Name _____ Employee First Name _____ MI _____ Date of Injury _____

Claims Administrator: _____ Claims Representative _____

Employer Name: _____ Employer Street Address: _____

Employer City: _____ State _____ Zip Code _____ Claim No. _____

- The Employee can return to regular work
- The Employee can work with **the following** restrictions:

	hours: 1-2	2-4	4-6	6-8	None
Standing Stand Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking Walk Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting Sit Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Bend Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forward Bending Squat Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling Climb Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling Twist Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting Reach Handle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keyboarding Crawl Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive Feel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach See	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Lift/Carry Restrictions: May not lift/carry at a height of _____ more than _____ lbs. for more than _____ hours per day.

Describe in what ways the impaired activities are limited:

DRAFT

R/L/Bilat Hand(s) (circle): Grasping

R/L/Bilat Hand(s) (circle): Pushing/Pulling

Other: (See below)

If a Job Description has been provided, please complete: **Job Description** Regular Modified Alternative Work

Job Title: _____ Work Location: _____

Are the Work Duties work capacities and activity restrictions compatible with the activity restrictions physical requirements set forth in the provided job description? Yes No, explain below

Physician's Name _____ Role of Doctor (PTP, QME, AME) _____

Physician's Signature _____ Date _____

State of California, Division of Workers' Compensation
Retraining and Return to Work Unit

Physician's Return-to-Work & Voucher Report Instructions
FOR INJURIES OCCURRING ON OR AFTER 1/1/13 ~~or injuries on or after January 1, 2013~~
DWC - AD 10133.36

Who is responsible for filling out this form? The first physician (**primary treating physician, Agreed Medical Evaluator, or Qualified Medical Evaluator**) who finds that the disability from all conditions for which compensation is claimed has become permanent and stationary (or has reached maximum medical improvement) and finds that the injury has caused permanent partial disability. ~~The physician can be the primary treating physician, a Qualified Medical Evaluator, or an Agreed Medical Evaluator.~~

What is the purpose of this form? The purpose of the form is to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The information contained on the form is for voucher purposes and is not considered in any permanent impairment rating or any permanent disability indemnity.

Is this a mandatory form? This is a mandatory attachment to the first medical report finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability. This form should be attached to a comprehensive medical-legal evaluation and does not replace such comprehensive medical-legal evaluations.

When does the form need to be completed? This form does not need to be completed until all conditions for which compensation is claimed have become permanent and stationary.

If the employer or claims administrator has provided the physician with a job description providing physical requirements of the employee's regular work, proposed modified work, or proposed alternative work, the physician **shall will** evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description. The bottom portion of the form does not need to be completed if the physician has not been provided with a job description.

Completing the employee's work restrictions: The physician should indicate work restrictions in terms of how many hours a particular activity **can be performed is restricted** during an 8-hour work day. For hand restrictions, the physician should indicate whether the restrictions are for the right hand, left hand, or both.

Other **R**estrictions can include psychiatric restrictions, chemical exposure, use of equipment, or any other restrictions. ***This space can also be used to further clarify or explain any of the checked restrictions.***

How does the employer receive the form? The claims administrator **shall will** forward the form to the employer.