

Reports of Work Ability

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Minn. R. 5221.0410, Subp. 6



Who Must Complete:

Employee's Primary Health Care Provider



When it Must be Completed:

Within 10 days of an insurer's request



How Often it Must Be Completed:

Every visit if visits are less frequent than once every two weeks;

Every two weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; or

Upon expiration of the ending or review date of the restriction specified in a previous report of work ability

What Information Must Be Included

- (1) information identifying the employee, employer, and insurer;
- (2) the date of the most recent examination;
- (3) information stating whether the employee is able to work without restrictions, able to work with restrictions, or unable to work;
- (4) work restrictions stated in functional terms, if the employee is able to work with restrictions;
- (5) the date any restriction of work activity is to begin and the anticipated ending or review date;
- (6) the date of the next scheduled visit; and
- (7) the signature of the health care provider, license or registration number, and identification information.

DLI Report of Work Ability

Mail to:
MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354

Report of Work Ability

See Instructions of Reverse Side

Print in ink or type
Enter dates in MM/DD/YYYY format



DO NOT USE THIS SPACE

This form must be provided to the employee.
(Minn. Rules 5221.0410, I subd. 6)

NOTICE TO EMPLOYEE: YOU MUST PROMPTLY PROVIDE A COPY OF THIS REPORT TO YOUR EMPLOYER OR WORKERS' COMPENSATION INSURER, AND QUALIFIED REHABILITATION CONSULTANT IF YOU HAVE ONE.

WID number or SSN	Date of injury	Date of birth
Employee		
Employer		
Insurer/Self-insurer-TPA		
Insurer claim number		

Date of most recent examination by this office _____

Select the appropriate option(s) below and fill in the applicable dates.

- ☐ Employee is able to work without restrictions as of _____ (date)
- ☐ Employee is able to work with restrictions, from _____ (date) to _____ (date)

The restrictions are:

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- ☐ Employee is unable to work from _____ (date) to _____ (date)

The next scheduled visit is: ☐ as needed OR _____

Name (Type or Print)			Signature		Degree
Address			State	License #/Registration #	
City	State	ZIP code	Phone # (include area code)		Date signed

Admin Report of Work Ability

Report of Workability

You must return this completed form to your employer as requested, or your return to work may be delayed or denied.

MD DEPARTMENT OF
ADMINISTRATION

Employee name: **Work Comp Claim #:**

Employee ID #:

Treatment Date: ____/____/____

Illness/Injury and Diagnosis Code:

Date of Injury: ____/____/____

☐ Work Related

☐ Not Work Related

☐ Undetermined

☐ Return to work with no limitations

☐ Immediately or

☐ Beginning ____/____/____

☐ Return to work with limitations on ____/____/____ through or next reassessment ____/____/____

☐ ____/____/____ through or next reassessment ____/____/____

Employee is released to work 1 2 3 4 5 6 7 8 9 10 + hours per day (circle one)

Employee is released to work 1 2 3 4 5 + days per week (circle one)

Employee is released to work overtime: **Yes** **No**

Has the employee been prescribed any medication which could cause drowsiness or impair ability to remain alert and aware? ☐

YES ☐ NO ☐ If yes, medication: _____

If yes, are there any special instructions given to the employee as to when or how to take the medication to limit impact to job duties? Please describe: _____

☐ Return to clinic on ____/____/____ Time: _____

EMPLOYEE'S CAPABILITIES
If restricted from performing a work activity for a reduced time period during the day, this means an employee is not able to perform that activity more than identified for the entire shift. Restrictions in effect 24 hours per day.

Lift/Carry	Not at all	<1 hr	1-3 hrs	3-6 hrs	6-7 hrs	8+ hrs	Drive	Not at all	<1 hr	1-3 hrs	3-6 hrs	6-7 hrs	8+ hrs	Upper Extremities	Not at all	<1 hr	1-3 hrs	3-6 hrs	6-7 hrs	8+ hrs
	at all	hr	hrs	hrs	hrs	hrs		at all	hr	hrs	hrs	hrs	hrs		at all	hr	hrs	hrs	hrs	hrs
0-10 lbs.	☐	☐	☐	☐	☐	☐	Heavy Equipment Car/pickup	☐	☐	☐	☐	☐	☐	Right	☐	☐	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	Left	☐	☐	☐	☐	☐	☐
21-40 lbs.	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	Both	☐	☐	☐	☐	☐	☐
41-60 lbs.	☐	☐	☐	☐	☐	☐	Positions Kneel/Squat Sit	☐	☐	☐	☐	☐	☐	Firm gripping/grasping	☐	☐	☐	☐	☐	☐
>60 lbs.	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	Outstretch arms	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	Overhead reaching	☐	☐	☐	☐	☐	☐
Push/Pull							Stand Walk Crawl	☐	☐	☐	☐	☐	☐	Vibrating tools	☐	☐	☐	☐	☐	☐
0-25 lbs.	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	Above Shoulder	☐	☐	☐	☐	☐	☐
26-50 lbs.	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐
51-75 lbs.	☐	☐	☐	☐	☐	☐	Trunk Comments: _____ _____ _____	☐	☐	☐	☐	☐	☐	Sensory/Environmental						
76-100 lbs.	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	Limitations	Yes	No	If yes, explain			
>100 lbs.	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	Hearing	☐	☐	_____			
Climb	Not at all	<1 hr	1-3 hrs	3-6 hrs	6-7 hrs	8+ hrs	Neck Comments: _____ _____ _____	☐	☐	☐	☐	☐	☐	Vision	☐	☐	_____			
Enter/exit heavy equipment with three-point contact.	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	Inside work	☐	☐	_____			
Ladder/stair	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	Outside work	☐	☐	_____			
													Well/humid	☐	☐	_____				