



STATE OF MISSOURI
OFFICE OF ADMINISTRATION

EARLY RETURN TO WORK - PHYSICAL ASSESSMENT

CENTRAL ACCIDENT REPORTING OFFICE (CARO)
P.O. BOX 809
JEFFERSON CITY, MO 65102
573/751-2837 FAX: 573/751-5262 OR 573/526-0820
1-888-622-7694

TO
The Treating Physician

The State of Missouri is committed to returning injured employees back to work as soon as possible. Please complete this form to assist us in accommodating any temporary modified duty restrictions. We ask that you be specific on this information based on medical findings. An alternative form may be used if it provides the same information.

PATIENT NAME	DATE OF INJURY	CARO NUMBER (IF KNOWN)
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EMPLOYER/AGENCY	DATE OF APPOINTMENT
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CONDITION
 Improved Symptoms Worse Unchanged

INJURED WORKER MAY RETURN TO WORK ON _____ / _____ / _____ with the following restrictions:

Stand	<input type="checkbox"/> 1-3 hrs	<input type="checkbox"/> 3-5 hrs	<input type="checkbox"/> 5-8 hrs	<input type="checkbox"/> No restriction
Walk	<input type="checkbox"/> 1-3 hrs	<input type="checkbox"/> 3-5 hrs	<input type="checkbox"/> 5-8 hrs	<input type="checkbox"/> No restriction
Sit	<input type="checkbox"/> 1-3 hrs	<input type="checkbox"/> 3-5 hrs	<input type="checkbox"/> 5-8 hrs	<input type="checkbox"/> No restriction
Lift	<input type="checkbox"/> Up to 10 lbs.	<input type="checkbox"/> 10-20 lbs	<input type="checkbox"/> 20-50 lbs	<input type="checkbox"/> Above 50 lbs <input type="checkbox"/> No restriction

EMPLOYEE IS ABLE TO:	NO RESTRICTION	CONTINUOUSLY 67-100%	FREQUENTLY 34-66%	OCCASIONALLY 11-33%	SELDOM 1-10%	NOT AT ALL
Lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HANDS/WRISTS:	NO RESTRICTION	CONTINUOUSLY 67-100%	FREQUENTLY 34-66%	OCCASIONALLY 11-33%	SELDOM 1-10%	NOT AT ALL
Typing/Keying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
File Handling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simple Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reach above Shoulders Yes No
 Work at Shoulder Level Yes No
 Drive/Operate Work Equipment/Machinery Yes No
 Maximum number of hours per day employee can work: 2 4 6 8 10 12 No Restriction Other

OTHER RESTRICTIONS: (PLEASE BE SPECIFIC)

DATE OF NEXT APPOINTMENT

PHYSICIAN SIGNATURE	DATE
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