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 New Mexico Institute of Mining and Technology 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 Worker's Compensation adjusting firm. The adjusting firm has to make the decision as to whether the claim is compensable, and the employee should be considered to be responsible for payment of your charges until the determination is made.

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_____ Previously: Yes_____ No_____
4. Medication prescribed? Yes_____No_____ Continued_____
   Will medication affect job performance? Yes_____No_____
5. Can employee return to normal duty at this time? Yes_____No_____
6. If "No", can employee return to work on a limited/restricted basis? Yes_____No_____
7. If "Yes", to #6, what restrictions? _____no reaching above shoulder. _____no pushing or pulling. _____ no climbing of stairs or ladders. _____ no operation of machinery. _____
   no lifting over ____lbs. _____ no repetitive waist bending. _____ no kneeling/squatting. _____limited/no use of_____.
   Other____ _____How long will restriction(s) last? Until next visit___ Other Date_____
8. When is next visit scheduled? _____
9. Other comments_____

ATTENDING DOCTOR_____

RMDWC2.FRM

MODIFIED WORK ASSIGNMENT

I, _____ have read the restriction 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