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 SHOULDERS
☐ NO CLIMING 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_____