

### **§ 2322E. Development of consistent forms for health care providers.**

(a) The Health Care Advisory Panel is authorized and directed to approve and propose standard forms for the provision of health care services pursuant to this chapter. Upon such recommendation, such forms and provisions governing their use shall be adopted by regulation of the Department of Labor, pursuant to Chapter 101 of Title 29. Such regulations shall be adopted and effective not later than 180 days after the first meeting of the Health Care Advisory Panel. Forms authorized by this section shall provide for prompt initial report of an employee's condition upon the initial occurrence of injury treated pursuant to this chapter and upon reasonable intervals thereafter to report the conditions and limitations of an employee. At a minimum the initial reporting form shall provide for an outline of the physical capabilities of the employee in order to enable and encourage the injured employee to return to work at the highest level of capability.

(b) The health care provider most responsible for the treatment of the employee's work-related injury shall complete and submit, as expeditiously as possible and not later than 10 days after the date of first evaluation or treatment, a report of employee condition and limitations, on a form adopted for that purpose pursuant to this section, and shall expeditiously provide copies of the report of employee condition and limitations to the employee, the employer and the employer's insurance carrier, if applicable. In the event that an employee is treated and released from the emergency department of a hospital, the health care provider most responsible for follow up care, if applicable, or the emergency room attending physician, shall provide the report of employee condition and limitations to the employee upon release, and the employee shall be responsible for provision of the report to the employer and the employer's insurance carrier, if applicable, within the time period provided by the rules adopted pursuant to this section.

(c) Every health care provider shall prepare supplemental reports of employee condition and limitations on forms prescribed pursuant to this section, and shall expeditiously provide copies of the report of employee condition and limitations to the employee, the employer and the employer's insurance carrier, if applicable.

(d) Within 14 days of receiving the initial "Physician's Report of Workers' Compensation Injury", the employer shall provide to the health care provider/physician who issued the aforementioned report and to the employer's insurance carrier, if applicable, a report of the modified-duty jobs which may be available to the employee. The health care provider portion of the employer's modified duty availability report must be signed and returned by the health care provider within 14 days of the next date of service after receipt of the form from the employer, but not later than 21 days from the health care provider's receipt of such form.

(e) Fees for completion, copying and transmission of the forms shall be developed by the Health Care Advisory Panel. The employer or the employer's insurance carrier shall be liable for payment of the fee for all such reports of employee condition and limitations, provided however, that the employer or insurance carrier shall not be liable for any such reports, requested by an employee more frequently than once during each 3-month period.

### **§ 2322F. Billing and payment for health care services.**

(g) If, following a hearing, the Industrial Accident Board determines that an employer, an insurance carrier or a health care provider failed in its responsibilities under § 2322B, § 2322C, § 2322D, § 2322E or § 2322F of this title, it shall assess a fine of not less than \$1,000 nor more than \$5,000 for violations of said sections. Such fines shall be payable to the Workers' Compensation Fund.

## **1341 Workers' Compensation Regulations**

### **6.0 Forms**

6.1 The Physician's Report of Workers' Compensation Injury "Progress" Report is to be completed by the health care provider and provided to the employee, the employer and the employer's insurance carrier, if applicable, upon any material change in the employee's physical capability which impacts the employee's return to work status. The "Progress" Report need not be completed by the health care provider upon each and every visit, but rather only in the instance of any material change in the injured employee's physical capability which impacts the employee's return to work status. "Progress" Reports provided in contravention of the above will not be subject to any charge for completion and submission.

6.2 The Physicians Report of Workers' Compensation Injury "Progress"

Report and Instructions (Physicians Form) follow.

6.3 The Employer's Modified Duty Availability Report and Instructions (Employers' Form) follow.

**PHYSICIAN'S FORM  
INSTRUCTIONS/DEFINITIONS**

**The use of this form is required by the Delaware Workers' Compensation Statute, 19 Del.C. §2322E, to report all information specific to this workers' compensation injury. In the event the physician electronically generates this information, the physician's submission is required to contain all information specific to this workers' compensation injury as set forth in the Physician's Form.**

*Complete all applicable fields. Your office notes and records do not replace this form.*

1. **Report Type:** Check "Initial" if this is the first visit related to this described injury. Check "Progress" when there has been any material change in the injured employee's physical capability which impacts the employee's return to work status. Check "Closing" if: injured worker is discharged from care.
2. **Case Information:**
  - ◆ **Injured Worker's Name:** Name of the injured worker.
  - ◆ **Date of Birth:** The injured worker's date of birth.
  - ◆ **Date of Injury:** Date of this injury.
  - ◆ **Exam Date:** Date of office visit if applicable.
  - ◆ **Physician's Phone/Fax:** The telephone and fax numbers of the physician completing this form.
  - ◆ **Employer Name:** The name of the employer associated with the claim.
  - ◆ **Employer Phone/Fax:** The telephone and fax numbers of the employer.
  - ◆ **Insurer Name:** The name of the insurance carrier associated with the claim, if known.
  - ◆ **Insurer Claim #:** The claim number assigned by the insurance carrier or self-insured employer, if known.
  - ◆ **Insurer Phone/Fax:** The telephone and fax numbers of the insurance carrier associated with the claim, if known.
3. **Initial Visit:** Relate in injured worker's words description of accident/injury.
4. **Work Related Medical Diagnosis(es):** State the injured worker's work related medical diagnosis(es).
5. **Treatment Plan:** Complete all applicable portions regarding treatment. Indicate frequency and duration.
  - ◆ **Diagnostic tools/tests:** EMG, MRI, CT-scan, etc.
  - ◆ **Procedures:** Any medical procedure including surgical procedures, castings, etc.
  - ◆ **Therapy:** Physical therapy, occupational therapy, home exercise, etc., including plan specifications.
  - ◆ **Medications:** Antibiotics, analgesics, anti-inflammatory drugs, etc.
  - ◆ **Other:** Any treatment not covered above.
6. **Hours Per Day Patient Can Work:** Circle the number of hours applicable to this patient.
7. **D.O.T. Classification of Work:** Circle the classification of work applicable to this patient.
8. **Work Postures/Positional Tolerances:** Comment as appropriate in the space provided regarding the patient's abilities/limitations for the postures/positions listed.
9. **Comments:** To be used to explain/clarify any information required by this form.
10. **Restrictions:** Check applicable category.
11. **Return to Work:** Provide regular duty/modified duty start date.
12. **Reevaluation Date:** Provide date of next evaluation.
13. **Physician Information:** Type or print the name of the physician and circle "yes" or "no" as to whether the physician is a Certified Provider. The health care provider most responsible for the treatment of the employee's work-related injury must sign and date the report.

**The health care provider most responsible for the treatment of the employee's work-related injury shall complete and submit, as expeditiously as possible and not later than 10 days after the date of first evaluation or treatment, a report of employee condition and limitations, on a form adopted for that purpose pursuant to this section, and shall expeditiously provide copies of the report of employee condition and limitations to the employee, the employer and the employer's insurance carrier, if applicable, as required by 19 Del. C. §2322E(b).**

DELAWARE WORKERS' COMPENSATION  
 PHYSICIAN'S REPORT OF WORKER'S COMPENSATION INJURY  
**A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER, EMPLOYER AND THE INSURER**

REPORT TYPE                       Initial                       Progress                       Closing

WORKER'S NAME: \_\_\_\_\_

DOB _____	Employer Name _____	
Date of Injury _____	Employer Phone/Fax _____	
EXAM DATE _____	Insurer Name _____	
Physician's Phone/Fax _____	Insurer Claim No. _____	
	Insurer Phone/Fax _____	

INITIAL VISIT ONLY  
 Injured worker's description of accident/injury \_\_\_\_\_

WORK RELATED MEDICAL DIAGNOSIS (I/S) \_\_\_\_\_

TREATMENT PLAN:  
 Diagnostic Tests \_\_\_\_\_  
 Procedures \_\_\_\_\_  
 Therapy \_\_\_\_\_  
 Medications \_\_\_\_\_

Hrs. per day patient can work: (circle one)      8      6      4      2      0

**D.O.T. Classification of Work** (Circle one)

- Sedentary    Exerting up to 10 lbs. of force *occasionally* and/or a negligible amount of force *frequently* to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.
- Light        Exerting up to 20 lbs. of force *occasionally* and/or up to 10 lbs. of force *frequently* and/or negligible amount of force *constantly* to move objects. Physical demand requirements are in excess of those for Sedentary Work.
- Medium     Exerting 20 to 50 lbs. of force *occasionally* and/or 10 to 25 lbs. of force *frequently* and or greater than negligible up to 10 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Light Work.
- Heavy       Exerting 50 to 100 lbs. of force *occasionally* and/or 25 to 50 lbs. of force *frequently* and/or 10 to 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Medium Work.
- Very Heavy   Exerting in excess of 100 lbs. of force *occasionally* and/or in excess of 50 lbs. of force *frequently* and/or in excess of 20 lbs. of force *constantly* to move objects. Physical Demand requirements are in excess of those for Heavy Work.

**Definitions:**  
**Occasionally:** activity or condition exists up to 1/3 of the time  
**Frequently:** activity or condition exists from 1/3 to 2/3 of the time  
**Constantly:** activity or condition exists 2/3 or more of the time

**Work Postures/Positional tolerances:** Comment **as appropriate** in the space provided regarding the patient's abilities/limitations for the following

Postures/Positions. (e.g. Sitting: No more than 30 minutes continuously)

Sitting: _____	Squatting: _____
Standing: _____	Crawling: _____
Walking: _____	Climbing: _____
Driving: _____	Repeated arm motions: _____
Bending: _____	Repetitive use of wrist/hands: _____
Turn/Twist: _____	Reaching up above shoulder: _____
Kneeling: _____	Foot controls: _____

Comments: \_\_\_\_\_

Above safe work capacities are: temporary \_\_\_\_\_ permanent \_\_\_\_\_ anticipate full duty release \_\_\_\_\_

Return to work modified duty start date: \_\_\_\_\_

RELEASE TO FULL DUTY WITH NO RESTRICTIONS (Please Circle) YES (Start date \_\_\_\_\_) NO

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: (Please print) \_\_\_\_\_ Certified Provider: YES NO

## EMPLOYER'S FORM INSTRUCTIONS/DEFINITIONS

The use of this form is required by the Delaware Workers' Compensation Statute, 19 Del.C. §2322E, to report all information specific to this workers' compensation injury.

*Complete all applicable fields.*

### 1. Case Information:

- **Employer Name:** The name of the employer associated with the claim.
- **Employee Name:** Name of the injured worker.
- **Modification Duty Information:** Complete all applicable fields
- **Employer Fax:** The telephone and fax numbers of the employer.
- **Job Title:** Provide job title for position available.
- **Job Description:** Provide description of physical requirements of job duties for position available.
- **Environment/Working Conditions:** Identify any environmental factors relevant to position available.

2. **Hours Per Day Job Available:** Circle the number of hours applicable.

3. **Additional Information:** Circle the applicable work status categories for the position available, and comment as appropriate in the space provided regarding the work postures/positional requirements for the modified duty job available.

4. **Employer:** Provide job availability date.

5. **Comments:** To be used to explain/clarify any information required by this form.

6. **Employer Information:** The person responsible for completing this form on behalf of the employer must sign and date this form.

**WITHIN FOURTEEN (14) DAYS OF RECEIVING THE INITIAL "PHYSICIAN'S REPORT OF WORKERS' COMPENSATION INJURY," THE EMPLOYER SHALL PROVIDE THIS FORM TO THE HEALTH CARE PROVIDER/PHYSICIAN WHO ISSUED THE AFOREMENTIONED REPORT AND THE EMPLOYER'S INSURANCE CARRIER AS REQUIRED BY 19 DEL.C. §2322E(D).**

**IF THE "PHYSICIAN'S REPORT OF WORKERS' COMPENSATION INJURY" RELEASES THE EMPLOYEE TO FULL DUTY, DO NOT COMPLETE THIS FORM.**

**THE HEALTH CARE PROVIDER/PHYSICIAN MUST COMPLETE HIS/HER PORTION OF THIS FORM AND SIGN AND RETURN IT TO THE EMPLOYER WITHIN FOURTEEN (14) DAYS OF THE NEXT DATE OF SERVICE AFTER THE PHYSICIAN'S RECEIPT OF THE FORM FROM THE EMPLOYER, BUT NOT LATER THAN TWENTY-ONE (21) DAYS FROM THE PHYSICIAN'S RECEIPT OF SUCH FORM.**

DELAWARE WORKERS' COMPENSATION  
EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT

DATE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ FAX#: \_\_\_\_\_

EMPLOYEE: \_\_\_\_\_

IS MODIFIED DUTY AVAILABLE:  Yes  No

IF AVAILABLE, FOR WHAT PERIOD OF TIME:  Weeks  Indefinite

JOB TITLE: \_\_\_\_\_

JOB DESCRIPTION: \_\_\_\_\_

ENVIRONMENT/WORKING CONDITIONS (e.g., Temperature): \_\_\_\_\_

Hrs. per day job available: (circle minimum and maximum)      8      6      4      2      0

**D.O.T. Classification of Work**      (Circle one)

- Sedentary**      Exerting up to 10 lbs. of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.
- Light**      Exerting up to 20 lbs. of force occasionally and/or up to 10 lbs. of force frequently and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work.
- Medium**      Exerting 20 to 50 lbs. of force occasionally and/or 10 to 25 lbs. of force frequently and or greater than negligible up to 10 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.
- Heavy**      Exerting 50 to 100 lbs. of force occasionally and/or 25 to 50 lbs. of force frequently and/or 10 to 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.
- Very Heavy**      Exerting in excess of 100 lbs. of force occasionally and/or in excess of 50 lbs. of force frequently and/or in excess of 20 lbs. of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.

**Definitions:**

**Occasionally:** activity or condition exists up to 1/3 of the time

**Frequently:** activity or condition exists from 1/3 to 2/3 of the time

**Constantly:** activity or condition exists 2/3 or more of the time

**Work Postures/Positional requirements:** Comment as appropriate in the space provided regarding the following Postures/Positions for the modified duty job available.

Sitting: _____	Squatting: _____	Standing: _____
Crawling: _____	Walking: _____	Climbing: _____
Driving: _____	Repeated arm motions: _____	Bending: _____
Turn/Twist: _____	Kneeling: _____	Foot controls: _____
Reaching up above shoulder: _____	Repetitive use of wrist/hands: _____	

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EMPLOYER: Date job is available: \_\_\_\_\_

Comments: \_\_\_\_\_

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICIAN: I approve the job described above.      ( ) Yes.      ( ) No.

If no, reasons for disapproval/recommended modifications: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name (Please print) \_\_\_\_\_ Certified provider: YES NO

**The Health Care Provider/Physician MUST complete his/her portion of this form and SIGN and RETURN it to the EMPLOYER within fourteen (14) days of the next date of service after the HC Provider/Physician's receipt of the form from the employer, but not later than twenty-one (21) days from the HC Provider/Physician's receipt off such form.**