Monterey County
Modified Work Activity Form

Employee Information (to be completed by Supervisor)	
Medical Provider	Liberty Mutual P.O. Box 989000 W. Sacramento, CA 95798-9800 Tel: (800) 821-0967 Fax: (603) 334-0231
We are sending:	
Date/Time Injured:	
Date being sent:	
Job Title:	
Brief Description of Accident:	Claim Number:

Physician: Please complete this form before the employee leaves the office today. Give the employee a copy and fax a copy to_____ ( )_____.

Employee Work Status: This patient has been instructed to:

☐ May return to Full Duty with no limitations or restrictions. ☐ May return to work a full _____ hour shift

☐ Return to Modified Work with restrictions listed below. ☐ May work _____ hours of a ____hour shift

(Please check one for each item)

Standing		No restrictions		No standing	Limited to	Hours/shift
Sitting		No restrictions		No sitting	Limited to	Hours/shift
Alternate Stand/Sit		Yes		No	Limited to	Hours/shift
Walking		No restrictions		No walking	Limited to	Hours/shift
Alternate Walk/Sit		Yes		No	Limited to	Hours/shift
Bending (Back)		No restrictions		No bending	Limited to	Hours/shift
Squatting (Knees)		No restrictions		No squatting	Limited to	Hours/shift
Reaching (Upper)		No restrictions		No reaching	Limited to	Hours/shift
Overhead Reaching		No restrictions		No reaching	Limited to	Hours/shift
Pushing (Back)		No restrictions		No pushing	Limited to	Hours/shift
Pulling (Back)		No restrictions		No pulling	Limited to	Hours/shift
Driving		No restrictions		No driving	Limited to	Hours/shift
Grasping (Hands)		No restrictions		No grasping	Limited to	Hours/shift
Keying (Hands)		No restrictions		No keying	Limited to	Hours/shift
Climbing		No restrictions		No climbing	Limited to	Hours/shift
Viewing Computer		No restrictions		No viewing computer	Limited to	Hours/shift

Other Restrictions

Weight Restriction: Employee limited to lifting (choose one)	☐ 5-10 lbs.	☐ 10-20 lbs	☐ 20-40 lbs.	☐50 lbs.	☐ No restrictions
Frequency of Lifting. Lifting as indication above is limited to (choose one):	☐ Occasionally (1 – 2x/hr)	☐ Frequently (3 – 4x/hr)	☐ Continuously (5+ x/hr)	☐ Other	

Exposures

Describe any chemical or mechanical exposure limitations:

Re-evaluation / Return to Full Duty

Employee will be re-evaluated on: **Anticipated date of return to full duty:**

Physician printed name:

Physician Signature: **Date:**