Claims | Claims Management of Missouri, LLC
Mgmt of MO

WORK DISABILITY SLIP

Date: _____ Time: _____ am/pm

Employee: _____
Employer/Location: _____
Date of Accident/Incident: _____

1. **Diagnosis: _____**

2. **Treatment Plan:**
   _____
   _____

3. **Work Status:**
   _____ **Employee may return to normal duties immediately**
   _____ **Employee is totally incapacitated at this time**
   _____ **Employee may return to Modified Duty with restrictions:**

   Hours/Day: _____None 8 hrs _____ 4 hrs _____ Other: _____

   Days/Week: _____None 5 days _____ 3 days _____ Other: _____

   Lifting: _____None 50 lbs _____ 40 lbs _____ 30 lbs _____
   20 lbs _____ 10 lbs _____ Other: _____

   Movement: _____None _____ limited stooping/climbing
   _____ limited bending/twisting
   _____ limited overhead/reaching
   _____ limited repetitive motion
   _____ other: _____

4. **Follow-up Doctor's Appointment: Date: _____ Time: _____am/pm**

5. **Medical Causation: Work Related? _____ YES _____ NO**

6. **Comments: _____**

Physician Signature: _____ Date: _____