



**Disability Management Medical Treatment Plan for Non-Occupational Disabilities**

Date of Injury: \_\_\_\_\_

**Employee Information:**

Employee Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Job Classification: \_\_\_\_\_ Dept/Bureau: \_\_\_\_\_  
 Supervisor/DMC: Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Injury Type: \_\_\_\_\_ DOB: \_\_\_\_\_

**Dear Attending Physician:** The City employee named above has alleged a temporary partial disability and has indicated a desire to be afforded a modified duty position. Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.

**Report of Physician:**

Diagnosis: \_\_\_\_\_  
 Referred to : \_\_\_\_\_ ( for additional medical care)

**Treatment Plan:**

SURGERY: \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ Outpatient \_\_\_\_\_ Inpatient  
 Anticipated procedure and date \_\_\_\_\_  
 OTHER TREATMENT: State specific modality and duration of treatments: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

ANTICIPATED DISABILITY FROM WORK: \_\_\_\_\_ No \_\_\_\_\_ Yes  
 Date able to return to work: Regular \_\_\_\_\_ Modified \_\_\_\_\_

**Current Physical Capacities:**

Please circle YES/NO as appropriate. Indicate hour per day allowed as needed. Note that some City of Norfolk employees work 10-hour days or 24-hour shifts.

Task	Status	Number of Hrs. /Comments
Standing	yes no	___ hours per day _____
Pushing/pulling	yes no	___ hours per day _____
Sitting	yes no	___ hours per day _____
Use of Hands	yes no	___ hours per day _____
Lifting	yes no	___ hours per day _____
Stooping/bending	yes no	___ hours per day _____
Walking	yes no	___ hours per day _____
Reaching	yes no	___ hours per day _____
Climbing stairs/ladders	yes no	___ hours per day _____
Operation of Commercial Vehicle, Equipment for/at work (forklift, ambulance, squad car, etc.)	yes no	___ hours per day _____

Additional medical information: \_\_\_\_\_

\_\_\_\_\_  
 Physician Signature M.D. Telephone # Date