Injury on Duty (IOD) Report

Date: _____

Time In: _____

Time Out: _____

Facility: _____ Medical Record #: _____ Front Desk Initials: _____

EMPLOYEE NAME: _____ HOME #: _____ Work #: _____

DATE OF BIRTH: _____ Emp ID #: _____ DEPARTMENT: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ ☐ INITIAL ☐ RECHECK

Please Check One

DESCRIPTION OF INJURY: _____

ASSESSMENT/DIAGNOSIS: _____

_____

Is condition claimed and compatible to be work related? ☐ Yes ☐ No

Are known pre-existing or other conditions contributing? ☐ Yes ☐ No

TREATMENT RENDERED: _____

_____

MEDICATIONS: _____

RETURN TO WORK OUTLINE

☐ RETURN TO REGULAR DUTY ☐ SENT HOME:___Today/Until_____

☐ LIMITED DUTY *If Not Available, must be off work until next visit ☐ DISCHARGED FROM CARE

☐ ADMITTED TO: _____

Restricted to: Occasional (1-33%) Frequent (34-66%) Continuous (67-100%)

☐ Tight Gripping ___L___R	☐ 1-33%	☐ 34-66%	☐ 67-100%	☐ None	
☐ Overhead Work ___L___R	☐ 1-33%	☐ 34-66%	☐ 67-100%	☐ None	
☐ Arm/hand use ___L___R	☐ 1-33%	☐ 34-66%	☐ 67-100%	☐ None	
☐ Sitting required	☐ 1-33%	☐ 34-66%	☐ 67-100%	☐ None	
☐ May stand/walk	☐ 1-33%	☐ 34-66%	☐ 67-100%	☐ None	
☐ Squatting or kneeling	☐ 1-33%	☐ 34-66%	☐ 67-100%	☐ None	
☐ Stoop/bend/twist	☐ 1-33%	☐ 34-66%	☐ 67-100%	☐ None	
☐ As Needed	☐ Use a brace	☐ Boot	☐ Crutches		
☐ 100% of time	☐ Use a brace	☐ Boot	☐ Crutches		

☐ Other: _____

☐ Weight limit____lbs. (back/lifting)

☐ No lift/push/pull over____lbs.

☐ Sitting job only

☐ Sitting job with foot/leg elevated

☐ May stand/walk up to ____hrs/day

☐ Alternate sit/stand, may walk short distances

☐ May stoop/bend/twist___times/hrs

☐ No safety sensitive duties

☐ No working heights/on ladders

☐ No driving company vehicles/bus

☐ No use of hazardous machinery

☐ No running/jumping

☐ No use of injured hand/arm

☐ No use of vibrating tools

☐ Keep dressing clean/dry

FOLLOW UP APPT. REQUIRED? ☐ Yes ☐ No ☐ As Needed DATE:_____/_____/_____ TIME: _____

REFERRAL TO SPECIALIST: _____

REFERRAL TO PHYSICAL THERAPY: _____

REFERRAL TO DIAGNOSTIC TESTING: _____

* Davies to make appointments

Physician's Name (Please Print): _____ Physician's Signature: _____

I understand this report and acknowledge receipt of a copy: **EMPLOYEE MUST RETURN A COPY TO THEIR SUPERVISOR**

I AGREE THAT: I will follow through with all of the restrictions listed above. I will notify my supervisor and Human Resources/Safety Coordinator of any departure from these restrictions.

Employee Signature: _____ Date: _____

FAX COMPLETED COPY TO DAVIES AT 615-360-5692 AND THEN RETAIN IN EMPLOYEE'S FILE. FORM – 201