King County

Department of Executive Services Human Resource Division
Safety & Claims Management, P.O. Box 80283, Seattle, Wa 98108
Phone 206-205-8575 Fax 206-296-0514

Activity Prescription Form

Worker's Name:	Visit Date:	Claim Number:
Health-care Provider's Name (printed):	Date of Injury:	Diagnosis:

Required: Released for work? *Check at least one*

☐ Worker is **released** to the job of injury without restrictions as of (date): ____/____/____ *Skip to "Plans" section below.*

☐ Worker **may perform modified duty**, if available, from (date):
_____/_____/_____ to _____/_____/_____

☐ Worker **may work limited hours**: _____hours/day from (date):
_____/_____/_____ to _____/_____/_____

☐ Worker **is working** modified duty or limited hours
Please estimate capacities below and provide key objective findings at right.

☐ Worker **not released to any work** from (date): ____/____/____ to ____/____/____

☐ **Prognosis poor for return to work** at the job of injury at any date

☐ May need assistance returning to work
Capacities apply 24/7, please estimate capacities below and provide key objective findings at right.

Required: Key Objective Finding(s)

Required: Estimate what the worker can do *Unless released to JOI*

Capacity duration (estimate days): ☐ **1-10** ☐ **11-20** ☐ **21-30** ☐ **30+** ☐ **permanent**

Worker can: (Related to work injury.) Blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% Not restricted
Sit					
Stand / Walk					
Climb (ladder / stairs)					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach **L**eft, **R**ight, **B**oth					
Work above shoulders **L, R, B**					
Keyboard **L, R, B**					
Wrist (flexion/extension) **L, R, B**					
Grasp (forceful) **L, R, B**					
Fine manipulation **L, R, B**					
Operate foot controls **L, R, B**					
Vibratory tasks; high impact					
Vibratory tasks; low impact					

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift **L, R, B**	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs
Carry **L, R, B**	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs
Push / Pull **L, R, B**	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐Yes ☐No
Modified duty available? ☐Yes ☐No
Date of contact: _____/_____/_____
Name of contact:_____
Notes:

Note to Claim Manager:

New diagnosis:_____

Opioids prescribed for: ☐ Acute pain or ☐ Chronic pain

Required: Plans

Worker progress: ☐ As expected / better than expected.
☐ Slower than expected. *Address in chart notes*

Current rehab: ☐ PT ☐ OT ☐ Home exercise
☐ Other_____

Surgery: ☐ Not Indicated ☐Possible ☐ Planned

Comments:

☐ Next scheduled visit in: _____ days, _____weeks.
☐ Treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? ☐Yes ☐No ☐Possibly
If you are qualified, please rate impairment for your patient.
☐ Will rate ☐ Will refer ☐ Request IME
☐ Care transferred to:_____
☐ Consultation needed with:_____
☐ Study pending:_____

Sign

Signature (**Required**): _____ ( )____-_____ Date: _____/_____/_____
☐ Doctor ☐ ARNP ☐ PA-C Phone number

☐ Copy of APF given to worker

Health Care Providers Please Return Immediately to fax 206-296-0514

Employees Please Return Immediately to fax 206-296-0514 and Your Supervisor or Base Chief