Dear Treating Physician

We are sending _____ to you to be seen for an industrial injury that
Employee's Name

occurred on ____/____/_____. We would like to handle this injury as first aid; as defined as
Date-of-Injury

> one-time treatment and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury which do not ordinarily require medical care. (Labor Code Section 6302, subdivision i)

However, if this injury does not meet the first aid criteria, please proceed with appropriate treatment. We respectfully request consideration for necessary restrictions; we will consider accommodations for modified duty to facilitate employee work participation during recover. Please use our attached work ability form, see behind this letter; this would be most helpful.

Please submit your Doctors' First Report of Injury, along with treatment requests, and billing to

> Trindel Insurance Fund
> P.O. Box 2069
> Weaverville CA 96093
> (530)623-2322
> (530) 623-5019 - fax

Please do not send a copy to the employer, thank you.

Very respectfully,

Travis Goings
Director of Risk Management
County of Plumas, Office of Risk Management

WORK ABILITY FORM

INSTRUCTIONS TO TREATING PHYSICIAN: We would like to put our employee back to work in a transitional duty job while he/she is recovering from this injury. Please complete this form and provide us with the tasks our employee is able to perform.

INSTRUCTIONS TO EMPLOYEE: Please provide this form to your treating physician at the beginning of your medical appointment. Return it to your employer immediately after your appointment.

Name of Employee		Todays Date
Name of Employer	Date of Injury (if applicable)	Claim Number (if applicable)
Diagnosis (ICD-9)	Prognosis	

1. Has the worker reached maximum medical improvement? ☐ Yes ☐ No
   If yes, please provide date: _____
   Date of next scheduled appointment: _____

2. Worker is released to:
   ☐ full duty — Date _____ (Do not complete lines 3 through11. Sign below.)
   ☐ modified duty — From (date) _____ Through (date) _____ (specify limitations below)
   ☐ modified hours - specify _____ — From (date) _____ Through (date) _____
   ☐ not yet released to work

	HOURS												
	No limitations	1	2	3	4	5	6	7	8	9	10	11	12
3. In a workday, worker can stand/walk a total of	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. At one time, worker can stand/walk	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. In a workday, worker can sit a total of	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. At one time, worker can sit	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

Pounds	>10	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80	85	90	95	100	>100
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequently	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. Worker can use hands for repetitive:

	Right		Left	
a. Fine manipulation	☐ Yes	☐ No	☐ Yes	☐ No
b. Pushing and pulling	☐ Yes	☐ No	☐ Yes	☐ No
c. Simple grasping	☐ Yes	☐ No	☐ Yes	☐ No
d. Power grasping	☐ Yes	☐ No	☐ Yes	☐ No
e. Keyboarding	☐ Yes	☐ No	☐ Yes	☐ No

Dominant Hand ☐ Right ☐ Left

9. Worker can use feet for repetitive raising and pushing (as in operating foot controls): ☐ Yes ☐ No

10. Worker is able to:

	Continuous 67-100% of the day	Frequently 34-66% of the day	Occasionally 6-33% of the day	Intermittently 1-5% of the day	Not at all
a. Squat	☐	☐	☐	☐	☐
b. Bend (neck)	☐	☐	☐	☐	☐
c. Bend (waist)	☐	☐	☐	☐	☐
d. Crouch	☐	☐	☐	☐	☐
e. Crawl	☐	☐	☐	☐	☐
f. Kneel	☐	☐	☐	☐	☐
g. Stoop	☐	☐	☐	☐	☐
h. Climb	☐	☐	☐	☐	☐
i. Balance	☐	☐	☐	☐	☐
j. Reach (above shoulder level)	☐	☐	☐	☐	☐
k. Reach (below shoulder level)	☐	☐	☐	☐	☐
l. Twist (neck)	☐	☐	☐	☐	☐
m. Twist (waist)	☐	☐	☐	☐	☐

11. Worker is able to drive a vehicle without restrictions: ☐ Yes ☐ No

12. Other functional abilities, limitations or modifications necessary in worker's employment: _____

Signature of Physician	Physician's typed name, address and contact information	Date

Rev. 2/2012

Plumas County Return to Work
Physician Release

Please Return via fax to 530-283-6442

Patient Name **Employer** Plumas County

Claim Number **Today's Date**

Please review the following temporary work assignments for the patient listed above:

☐

☐

Return-to-Work Release Date: _____

Approved with the modifications specified below:

Return-to-Work Release Date: _____

Disapproved for the following medical reasons:

Doctor's Signature & Date: _____

Date

Estimated Return to Full Duty Date: _____

TO BE COMPLETED BY EMPLOYER:

We have read and understand the requirements and physical capacities of the temporary work assignments and all related physician's modifications. We agree to respect the conditions.

_____

(Employer Representative Signature) (Date)

_____

(Employee Signature) (Date)

Mitchell ScriptAdvisor

Trindel Insurance Fund

First Fill – Temporary Prescription Card

Trindel Insurance Fund – [Employer Name]

Mitchell ScriptAdvisor has been selected by **Trindel Insurance Fund** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription.

For your convenience, **Mitchell** ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number or visit our website at **www.ipsusa.com** use the pharmacy locator.

Employee

- Please contact Customer Service at 866.846.9279 to request activation of your Temporary Prescription ID.
- Fill in the ID number supplied by Mitchell Customer Service along with your name on the ID card below.
- Present this sheet to the pharmacist along with your prescription.

Pharmacy

- This sheet is a Temporary Prescription ID Card for a **30** Days' Supply Fill until this individual's permanent card can be provided.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Member Name:

Member ID #:

Rx BIN: 004410

PCN: SCI

Questions? Contact us at

This card is to be used for prescriptions related to your workers' compensation injury-related injuries covered under your insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

mitchell