



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,

Nicholas Poole  
Assistant Risk Manager  
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		Today's Date	
Name of Employer		Date of Injury (if applicable)	Claim Number (if applicable)
ICD-9 nosis		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 through 11. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. At one time, worker can stand/walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In a workday, worker can sit a total of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. At one time, worker can sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Worker can use hands for repetitive:

	Right	Left	
a. Fine manipulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Pushing and pulling	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dominant Hand <input type="checkbox"/> Right <input type="checkbox"/> Left
c. Simple grasping	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. Power grasping	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e. Keyboarding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Bend (neck)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Bend (waist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Reach (above shoulder level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Reach (below shoulder level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Twist (neck)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Twist (waist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
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# Plumas County Return to Work Physician Release

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Please Return via fax to 530-283-6442

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**Patient Name**

**Employer**

Plumas County

**Claim Number**

**Today's Date**

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

**Return-to-Work Release Date:** \_\_\_\_\_

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Approved with the modifications specified below:

**Return-to-Work Release Date:** \_\_\_\_\_

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Disapproved for the following medical reasons:

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Doctor's Signature &  
Date:

\_\_\_\_\_ **Date**

**Estimated Return to Full Duty Date:** \_\_\_\_\_

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**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)

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## 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](http://www.ipsusa.com) use the pharmacy locator.




### Employee

- Please contact Customer Service at 866.845.9279 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.

<b>Mitchell ScriptAdvisor</b>		
Temporary Prescription Benefit Card		
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.