STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
CHS. 102 AND 230.36, WIS. STATS.
DOA-6125 (R05/2007)

INSTRUCTIONS:
Physician: Complete Section II Including Reverse Side, And Return Completed Form To The Employing Agency Listed.

# Physician's Certification

This form can be made available in alternate formats to individuals with disabilities upon request.

## I. General Information - To be completed by employing agency

| Employee Name (As appears on Payroll) | Date of Accident (mm/dd/ccyy) | Date of Birth (mm/dd/ccyy) |
|---|---|---|
| Employing Agency - Include Street Address or P.O. Box, City, ZIP + 4 | Agency Contact Person | Claim Number<br>Phone Number |
| Brief Work Description | Description of Injury: The employee claims the injury or disease occurred as follows: | |

## II. Physician's Statement - To be completed by physician. Required for worker's compensation payments.

The above named employee is applying for benefits through either Worker's Compensation (Ch. 102, Wis. Stats.) or "Hazardous Employment" (Sec. 230.36,7, Wis. Stats.) with the State of Wisconsin.

| Physician's Name (Type or Print) | Date of Initial Treatment | Date of Last Treatment/Exam |
|---|---|---|
| Address | Is employee currently under your care for job related injury or disease?<br>☐ Yes ☐ No | Has employee been discharged from treatment for this injury?<br>☐ Yes ☐ No |

**Diagnosis:** I hereby certify that the above named employee is under my care for: (Describe physical problems resulting from injury or disease.)

Is it your opinion to a reasonable degree of medical certainty that the above named individual's condition resulted from the circumstances surrounding the job-related injury or disease described by the employee?

☐ Yes – Indicate the reasoning that led to this conclusion:

☐ No

| Did this employee have a pre-existing condition prior to the work injury? | Did the work injury aggravate the pre-existing condition beyond normal progression? |
|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No |

Do you expect that any further treatment will be necessary to cure or relieve the employee from the effects of this injury?

☐ Yes – How much longer and what type of treatment? (include prescribed medications)

☐ No

| Date employee will be able to resume work:<br>☐ Actual<br>☐ Estimated | Prognosis: | |
|---|---|---|
| Return to work - Check all that apply.<br>☐ Full Time ☐ Without Work Restrictions<br>☐ Half Time ☐ With Work Restrictions as Checked on Page 2.<br>☐ Other – Please Specify: | Has employee been advised?<br>☐ Yes ☐ No | Is permanent disability expected?<br>☐ Yes – Complete REVERSE SIDE<br>☐ No |

**Work Restrictions:** Employees may be assigned to alternate work duties while recovering from their injury. Assigned duties will be based on limitations determined by the doctor.

**Check Current Work Performance Limitations**

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking or standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree of pushing and pulling of arm and/or leg controls.

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 55 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Light Heavy Work.** Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

**1. In an 8 hour work day patient may:**

**a. Stand / Walk**
☐ None ☐ 4-6 Hours
☐ 1-4 Hours ☐ 6-8 Hours

**b. Sit**
☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours

**c. Drive**
☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours

**2. Patient may use hand(s) or repetitive motion**
☐ Single Grasping ☐ Pushing & Pulling
☐ Fine Manipulation

**3. Patient may use foot / feet for repetitive movement as in operating foot controls:**
☐ Yes ☐ No

**4. Patient may:**

| | Not at all | Occasionally (1-33%) | Frequently (34-66%) | Continuously (67-100%) |
|---|---|---|---|---|
| **a. Bend** | ☐ | ☐ | ☐ | ☐ |
| **b. Twist** | ☐ | ☐ | ☐ | ☐ |
| **c. Squat** | ☐ | ☐ | ☐ | ☐ |
| **d. Climb** | ☐ | ☐ | ☐ | ☐ |
| **e. Reach** | ☐ | ☐ | ☐ | ☐ |

Will above limitations be:
☐ Temporary, until (date – mm/dd/ccyy):

☐ Permanent

Other activities which may be harmful:

Other conditions which may be harmful:

Date of End of Healing or Healing Plateau (mm/dd/ccyy): _____
☐ Actual ☐ Estimated (If estimated, what further medical improvement is expected?)

**If healing has not ended**, what is the minimum percent of permanent disability expected?

Approximately what date can a final permanent disability be given? (mm/dd/ccyy)

**Permanent Disability: By law, under Wis. Admin. Code Ind. 80.02(2)(e), the physician must respond if temporary disability exceeded three weeks or if permanent disability resulted.**
What permanent disability has resulted? Provide percentage & describe elements such as limitation of motion, pain, weakness, etc.

☐ Check if NO permanent disability resulted.

Additional Comments:

Physician's Signature

Date signed - (mm/dd/ccyy)