

CorVel Work Ability Report

Today's Date _____

New Follow Up

CorVel Enterprise Comp
PO BOX 540220, Omaha, NE 68154
800-825-9543 Fax 866-427-2691

Employee Section

Name _____ Last 4 Digits of SSN _____

Home Address _____ City _____ State _____ Zip _____ Home Phone _____

Sex (male/female) _____ Occupation _____ Department _____

Scheduled Hrs/Week _____ Supervisor's Name _____ Work Phone _____

Date of Injury/Illness _____ Time Work Shift Began _____ Time of Incident _____

Describe the injury or illness in detail and indicate the part of body affected. (BE SPECIFIC; i.e. 2" laceration to right forearm, low back strain, etc.)

Any pain/discomfort on other parts of your body, in addition to the injured site? Please describe:

How did the accident or injury occur? What were you actually doing?

Name the object or substance that directly caused the injury, or any safety concerns you may have:

Provider Section

Provider Name _____ Provider Phone _____

Injury Treatment

Diagnosis/Condition _____

Treatment Plan _____

RELATIVE TO THE ABOVE CONDITION(S) ONLY, please identify:

Return to Work - No Restrictions Date _____

No Work Until _____

Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools.

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

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

Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 30 pounds.

Medium-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.

These restrictions are in effect until: _____

1. In a 8-hour work day, patient may:
 - a. Stand/Walk Occasionally Frequently Consistently
 - b. Sit Occasionally Frequently Consistently
 - c. Drive Occasionally Frequently Consistently
2. Patient may use hand(s) for repetitive:
Single Grasping Pushing/Pulling Fine Manipulation
3. Patient may use foot/feet for repetitive motion:
Frequently Consistently
4. Patient is able to: Occasionally, Frequently, Consistently
None 1-33% 34-66% 67-100%
 - a. Bend
 - b. Squat
 - c. Climb
 - d. Twist
 - e. Reach
5. Other Restrictions:

Is further treatment required for this injury? Yes No Next Evaluation: Date _____ Time _____

Patient Instructions/Comments _____

Provider's Signature _____ Date _____

Employee Signature _____ Date _____