State Fund Claims: Dept. of Labor and Industries - Claims Section
PO Box 44291, Olympia WA 98504-4291

Self-Insured Claims: Contact the Self Insured Employer (SIE)/ Third Party Administrator (TPA)*

INSURER ACTIVITY PRESCRIPTION FORM (APF)

Reminder: Send chart notes and reports to L&I or to SIE/TPA as usual

Billing Code: 1073M (Guidance on back)

General Info

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

Released for work? *Check one*

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

☐ Worker **may perform modified duty** (altered duties or limited hours), if available, from (date): ____/____/____ to ____/____/____ for _____hours/day

Estimate physical capacities below and complete the Key Objective Findings to the 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

Estimate physical capacities below and complete the Key Objective Findings to the right.

Key Objective Finding(s)
Required for time-loss payment decisions

Doctor's Estimate of Physical Capacities

☐ **Temporary Restrictions** ☐ **Permanent / Indefinite Restrictions**

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 Left, Right, Both					
Work above shoulders L, R, B					
Keyboard					
Wrist (flexion/extension) L, R, B					
Grasp (forceful) L, R, B					
Fine manipulation L, R, B					
Operate foot controls L, R, B					

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	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs

Other Restrictions / Instructions:

Approved Absence Dates:

Employer Notified of restrictions? ☐Yes ☐No
Date notified: ___/___/___
Modified duty: ☐ Available ☐ Not available
Notes:

Note to Claim Manager:

Plans

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

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

Surgery: ☐ Indicated / planned ☐ Not indicated

Comments:

☐ Next scheduled visit is: ____/____/____

☐ None, treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? ☐Yes ☐No ☐Possibly
Will you rate impairment? ☐Yes, *please attach* ☐No
If not, will you refer for a rating consultation? ☐Yes ☐No

☐ Care transferred to:_____

☐ Study pending:_____

☐ Consultation scheduled with:_____

Sign

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

☐ Copy of APF given to worker (to show it to employer) ☐ Talking points (on back) discussed with worker

State Fund Claims: Fax to claim file. *Choose any number:* 360-902-4292 360-902-4565 360-902-4566 360-902-4567 360-902-5230 360-902-6100 360-902-6252 360-902-6460

*Self-Insured Claims: For a list of SIE/TPAs, go to: www.lni.wa.gov/download/Selfins/Rpt4097d.txt