



Instructions

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
The treating physician must submit this form each time they see the injured worker unless they:
Have been awarded permanent and total disability.
Have returned to work without restrictions within seven days of the injury.
Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

Note: Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-fund or to the employer if self-insured.
Important: Failure to provide complete information may delay compensation payments to the injured worker.

Form with sections: Injured worker name, Claim number, Date of injury, Date of last appointment/examination, Date of this appointment/examination, Date of next appointment/examination, Submission type (Select one of the options below.), Job description and work status, Disability information, and a table for work-related allowed conditions.

Injured worker name	Claim number	Date of injury
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4	<b>Abilities, clinical findings, and recovery progression</b>		<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes			
	<ul style="list-style-type: none"> <li>• Is the Injured worker taking prescribed medication for the allowed conditions that may be a safety hazard? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Dominant hand: <input type="checkbox"/> Right <input type="checkbox"/> Left</li> <li>• Circle the injured worker's physical abilities for the activities in the chart below and provide comments as necessary.</li> </ul>					
	<b>Frequency scale</b>		<b>Strength level (lbs.)</b>		<b>Body side indicator</b>	
	<b>N</b> = Never <b>S</b> = Seldom 0-1 hour <b>O</b> = Occasional 1-3 hours <b>F</b> = Frequent 3-6 hours <b>C</b> = Constant 6-8 hours		<b>S</b> = Sedentary 0-10 <b>L</b> = Light 0-20 <b>M</b> = Medium 0-50 <b>H</b> = Heavy 0-100 <b>VH</b> = Very heavy >100		<b>L</b> = Left <b>R</b> = Right <b>B</b> = Both  <small>*Indicate limitations ONLY</small>	
	<b>Activity</b>	<b>Frequency</b>	<b>Activity</b>	<b>Strength</b>	<b>Frequency</b>	<b>Activity</b>
	Sit	<b>N S O F C</b>	Floor lift (0-17")	<b>S L M H VH</b>	<b>N S O F C</b>	Front/Lateral reach
	Stand/Walk	<b>N S O F C</b>	Knee lift (18-29")	<b>S L M H VH</b>	<b>N S O F C</b>	Overhead reach
	Climb stairs	<b>N S O F C</b>	Waist lift (30-36")	<b>S L M H VH</b>	<b>N S O F C</b>	Wrist flex/extension
	Squat/Kneel	<b>N S O F C</b>	Chest lift (37-60")	<b>S L M H VH</b>	<b>N S O F C</b>	Grasp
	Crawl	<b>N S O F C</b>	Overhead lift (>60")	<b>S L M H VH</b>	<b>N S O F C</b>	Finger manipulation
Twist	<b>N S O F C</b>	Push/Pull	<b>S L M H VH</b>	<b>N S O F C</b>	Keyboarding	
Bend/Stoop	<b>N S O F C</b>	Carry	<b>S L M H VH</b>	<b>N S O F C</b>	Operate foot controls	

	<ul style="list-style-type: none"> <li>• Injured worker can work _____ hours per day and _____ hours per week.</li> <li>• Are there any functional restrictions based only on the allowed psychological conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No           <ul style="list-style-type: none"> <li>◦ If yes, describe any functional restrictions in comments below and reference the MEDCO-16 as needed.</li> </ul> </li> <li>• Provide your clinical and objective findings supporting your medical opinion. List barriers to return to work, reason(s) for delayed recovery, and proposed treatment plan (e.g., modalities, therapies, surgery), including estimated duration of each treatment or indicate if all or part of this information is in office notes (include date(s) of notes).</li> </ul> <p><b>Comments:</b></p>    <p><b>Health and Behavioral Assessment:</b> (HBA evaluates cognitive, emotional, social, and behavioral barriers that might impact physical health problems and treatments which are associated with the allowed physical injury in the claim.)</p> <ul style="list-style-type: none"> <li>• Is the injured worker's recovery not progressing, or progressing slower than expected? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Do cognitive, emotional, social, or behavioral barriers exist that may be interfering with expected healing? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p><b>Vocational rehabilitation</b> is a voluntary program for an eligible injured worker who needs assistance to remain at work or return to work. Is the injured worker currently able to participate in a vocational rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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5	<b>Maximum medical improvement (MMI) status</b>		<input type="checkbox"/> Reporting changes from last evaluation <input type="checkbox"/> No changes	
	<p><b>MMI</b> is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> <li>• <b>If yes</b>, give MMI date: ____/____/____. <b>Note:</b> An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. So, periodic medical treatment may still be requested and, if approved, provided.</li> </ul>			

6	<b>Treating physician's signature – mandatory (See exceptions at the top of the form.)</b>			
	<p>I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a fine or imprisonment or both.</p>			
	Treating physician's name (Print legibly.)		Address, city, state, nine-digit ZIP code	
	Treating physician's signature			
BWC provider (PEACH) number		Date	Telephone number	Fax number