DELAWARE ORTHOPAEDICS AND SPORTS MEDICINE, PA

Ortho*Ready* Walk-In

Phone: 302-730-0840 • Fax: 302-730-3006

230 Beiser Boulevard • Suite 100 • Dover, Delaware 19904

Work Injury Details / Job Requirements Questionnaire

Patient Name:_____ Date of Birth: _____

Employer:_____ Job Title:_____

Supervisor Name:_____ Phone#: _____

Date of Work Injury:_____

Please describe how the injury occurred. Be as specific as possible, include all details:_____

_____

_____

_____

Please describe your regular job duties/responsibilities: _____

_____

How many hours do you work per day? _____ How many days do you work per week? _____

List any special equipment, machines or tools that you are required to use on the job:_____

_____

PHYSICAL DEMANDS OF YOUR JOB:

Sitting Total of_____hours per day. Standing Total of_____hours per day.

Walking Total of_____hours per day. Lifting/Carrying Total of_____pounds.

Are there any aspects of your job that you have difficulty with or are not able to do since your injury?_____

If yes please describe: _____

_____

******Please answer all questions. If this does not apply to you, please answer N/A. Thank you.******

I certify that the information on this document is true and correct to the best of my knowledge.

_____ _____

Signature Date