State Fund Claim:
Department of Labor and Industries
PO Box 44291 Olympia WA 98504-4291
Fax to claim file: 360-902-4567

Self-Insured Claims: Contact the Self Insured Employer (SIE)/Third Party Administrator (TPA)
For a list of SIE/TPAs, go to www.Lni.wa.gov/SelfInsured

Activity Prescription Form (APF)

Billing Code: 1073M (Guidance on back)

Reminder: Send chart notes and reports to L&I or SIE/TPA as required. Complete this form only when there are changes in medical status or capacities, or change in release for work status.

General info

Worker's Name:	Patient ID:	Visit Date:	Claim Number:
Gonzales, Anna M	03752200	06/10/2024	Bk97510
Healthcare Provider's Name (please print):		Date of Injury:	Diagnosis:
Rose, Joel Terrance, PA-C		06/10/2024	Sprain of left ankle

Required: Work status

☐ Worker is **released** to the job of injury (JOI) without restrictions (related to the work injury) as of (date): _____
(If selected, skip to "Plans" section below)

☐ Worker **may perform modified duty**, if available, from (date): _____ to* _____ (*estimated date)
☐ If released to modified duty, may work more than normal schedule
☐ Worker **may work limited hours**: _____ hours/day from (date): _____ to* _____ (*estimated date)
☐ Worker **is working** modified duty or limited hours _____

☒ Worker **not released to any work** from (date): 06/11/2024 **to*** 06/15/2024 (*estimated date)
☐ **Poor prognosis for return to work** at the job of injury at any date

Required: Measurable Objective Finding(s) ***(also referred to as Objective Medical Findings)*** (e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)

Swelling, tenderness to left lateral malleolus, ATFL

Required: Estimate what the worker can do at work and at home unless released to JOI

How long do the worker's current capacities apply (estimate)?
☐ **1-10 days** ☐ **11-20 days** ☐ **21-30 days** ☐ **30+ days** ☐ **permanent**

Capacities apply all day, every day of the week, at home as well as at work.

Worker can: (Related to work injury) A 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					
Perform work from ladder					
Climb ladder					
Climb stairs					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach					
Work above shoulders					
Keyboard					
Wrist (flexion/extension)					
Grasp (forceful)					
Fine manipulation					
Operate foot controls					
Vibratory tasks; high impact					
Vibratory tasks; low impact					

Lifting / Pushing	**Never**	**Seldom**	**Occas.**	**Frequent**	**Constant**
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift	lbs	lbs	lbs	lbs	lbs
Carry	lbs	lbs	lbs	lbs	lbs
Push / Pull	lbs	lbs	lbs	lbs	lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐Yes ☐No
Modified duty available? ☐Yes ☐No
Date of contact: _____
Name of contact: _____
Notes:

Note to Claim Manager:

☐ May need assistance returning to work
New diagnosis: _____
Opioids prescribed for: ☐Acute pain or ☐Chronic pain

Required: Plans

Worker progress: ☐ As expected / better than expected ☐ Slower than expected (*address in chart notes*)

Current rehab: ☐ PT ☐ OT ☐ Home exercise ☐ Other (e.g., Activity Coaching) _____

Surgery: ☐ Not Indicated ☐ Possible ☐ Planned Date: _____ ☐ Completed Date: _____

☐ Next scheduled visit in: ___days ___weeks or Date: _____
☐ Treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? ☐Yes ☐No ☐Possibly
If you are qualified, please rate impairment for your patient
☐Will rate ☐Will refer ☐Request IME
☐ Care transferred to: _____
☐ Consultation needed with: _____
☐ Study pending: _____

Req: Sign

☒ Copy of APF given to worker ☒ Discussed three key messages on back of form with patient

Signature: Rose, Joel Terrance, PA-C — 384687 (L&I ID) — 06/10/2024 (Date) — 253-596-3300 (Phone)

☐ Doctor ☐ ARNP ☒ PA-C