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: Joel C Flores	Patient ID: 108-928-111	Visit Date: 04/01/2025	Claim Number: BL60898
Healthcare Provider's Name (please print): Stuart M Austin, PA-C		Date of Injury: 02/27/2025	Diagnosis: S76.211A See attached for complete DX codes and descriptions.

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): 04/01/2025 to* 4/15/25 (*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): _____ **to*** _____ (*estimated date)

☐ **Poor prognosis for return to work** at the job of injury at any date

Required: Measurable Objective Finding(s)
(e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)
Inguinal tenderness with palpation and cough

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	Both	21 lbs	20 lbs	___ lbs	___ lbs	___ lbs
Carry	Both	21 lbs	20 lbs	___ lbs	___ lbs	___ lbs
Push / Pull	Both	21 lbs	20 lbs	___ lbs	___ lbs	___ lbs

Other Restrictions / Instructions:
Limited standing and walking

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: 04/15/2025
☐ 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: _____

I gave to worker? Copy of APF ☐ Discussed three key messages on back of form with patient

Stuart Austin PA-C
☐ Doctor ☐ ARNP ☐ PA-C

04/01/2025
Date

(206) 624 - 3651
Phone

Reg: Sign

☑ Copy of APF

Signature: _____