

FLORIDA DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY
DIVISION OF WORKERS' COMPENSATION
BUREAU OF REHABILITATION AND MEDICAL SERVICES
 2728 Centerview Drive, 100 Forrest Building
 Tallahassee, Florida 32399-0664

MAXIMUM MEDICAL IMPROVEMENT/PERMANENT IMPAIRMENT DETERMINATION CERTIFICATION FORM

PHYSICIAN: Complete this form and submit original to the carrier and a copy to the employee. EMPLOYEE: If you have any questions or concerns about the information on this form, contact the Employee Assistance Office at 1-800-342-1741.

EMPLOYEE'S NAME	SOCIAL SECURITY NUMBER	DATE OF ACCIDENT
CARRIER'S NAME & ADDRESS		EMPLOYER'S NAME & ADDRESS

NOTICE TO PHYSICIAN AND EMPLOYEE: For dates of accident on or after 01/01/1994, all medical care rendered after the date of maximum medical improvement requires a co-payment of \$10 from the employee on all non-emergency future medical visits.

Maximum Medical Improvement attained on:	Does this date reflect that the employee has reached MMI for all body areas injured: <input type="checkbox"/> Yes <input type="checkbox"/> No
Percentage of Permanent Impairment to body as a whole: %	Does this Permanent Impairment rating apply to all body areas injured: <input type="checkbox"/> Yes <input type="checkbox"/> No

RATING GIVEN ACCORDING TO THE FOLLOWING:

<input type="checkbox"/> American Medical Association's Guide	Edition: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 3rd(R)	Section(s) used:
<input type="checkbox"/> Minnesota Guides	Section(s) used:	
<input type="checkbox"/> 1993 Florida Impairment Rating Guide	Section(s) used:	
<input type="checkbox"/> 1996 Florida Uniform Permanent Impairment Rating Schedule	Section(s) used:	
Does this employee have work restrictions: <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", describe restrictions using the descriptive restrictions chart on the reverse side of this form.	

What type of future treatment is anticipated?

It is the responsibility of the appropriate treating physician to provide copies of medical records pursuant to s. 440.13, Florida Statutes and as required, to determine this injured worker's date of maximum medical improvement, and if necessary, rate any permanent impairment pursuant to s. 440.15(3)(a), Florida Statutes.

Physician's Name, Address & Telephone Number	Physician's DBPR Number
	Date Prepared

ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

DESCRIPTIVE RESTRICTIONS CHART

NOTE: In terms of an 8 hour day:

Occasionally	= 0 to 33%
Frequently	= 34 to 66%
Continuously	= 67 to 100%

I. In an 8 hour work day, the patient can: (circle hours anticipated for each activity without interruptions)

A. Sit	0	1	2	3	4	5	6	7	8
B. Stand	0	1	2	3	4	5	6	7	8
C. Walk	0	1	2	3	4	5	6	7	8

II. The patient can lift:

	<u>Occasionally</u>	<u>Frequently</u>	<u>Continuously</u>
A. Up to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. 11 to 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. 21 to 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. 51 to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. The patient can carry:

	<u>Occasionally</u>	<u>Frequently</u>	<u>Continuously</u>
A. Up to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. 11 to 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. 21 to 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. 51 to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. The patient is able to:

	<u>Occasionally</u>	<u>Frequently</u>	<u>Continuously</u>
A. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

V. The patient can use hands for repetitive action such as:

	<u>Dominant</u>	<u>Simple Grasping</u>	<u>Pushing-Pulling</u>
A. Right hand	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Left hand	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

VI. The patient can use feet for repetitive movements, as in operating foot controls or levers:

A. Right foot	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Left foot	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Both feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No

VII. Restrictions of activities involving

	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Total</u>
A. Unprotected heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Being around moving machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Exposure to marked changes in temperature and humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Driving automotive equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Fumes and gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Restricted to Automatic Transmission	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Comments: