MODIFIED WORK PROPOSAL
for workers with ELBOW problems

Employee name: __________________________ Site of injury: __________________ Date: __________

Proposed tasks: __________________________

Description of proposed tasks: __________________________________________________________

With the employee’s participation, we have reviewed the physical work demands for the elbow of the proposed tasks using the “Estimate of physical work demands for workers with elbow problems” worksheet. Here are the results:

<table>
<thead>
<tr>
<th>Work demands</th>
<th>Estimate of physical work demands</th>
<th>Describe the characteristics of the moderate and high work demands (e.g. duration, frequency, intensity) and any changes applied</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Absent</td>
<td>Low</td>
</tr>
<tr>
<td>1</td>
<td>Forceful gripping, holding or squeezing</td>
<td>✗</td>
</tr>
<tr>
<td>2</td>
<td>Awkward postures for the elbow (e.g. pronation/supination of forearm, radial/ulnar deviation of wrist, flexion/extension of wrist or fingers)</td>
<td>✗</td>
</tr>
<tr>
<td>3</td>
<td>Exposure of the hands to vibration, impact shock or rebound</td>
<td>✗</td>
</tr>
<tr>
<td>4</td>
<td>Pressure or friction points in the elbow area</td>
<td>✗</td>
</tr>
</tbody>
</table>

The employee believes he or she is capable of performing the work:

- [ ] as described above
- [ ] if the worker can work at his or her own pace
- [ ] The employee does not believe he or she is capable of performing this work

To be completed by the treating physician:

1. Is the employee able to perform this work?  
   - [ ] yes  
   - [ ] no
2. Is this work without danger to the health, safety and physical well being of the employee, given his or her injury?  
   - [ ] yes  
   - [ ] no
3. Does this work promote the rehabilitation of the employee?  
   - [ ] yes  
   - [ ] no

Assignment permitted:  
   - [ ] yes  
   - [ ] no  
   - [ ] yes with the following changes or restrictions: __________________________

If no, reason for refusal: __________________________

Start date of this work assignment: __________________________

I recommend that this person be re-evaluated in _______ days.

Signature of treating physician: __________________________ Date: __________

Name in block letters: __________________________