

**INJURED STAFF/MEMBER
Letter from Treating Provider****Section 1 – Conservation Legacy’s Worker’s Compensation Insurance Information**

Company – Sedgwick PO Box 14156 Lexington, KY 40512-4156	Prescription Drug Insurance: Sedgwick - Cadence RX cadencerx.com/find-a-pharmacy/
Policy #: ZAWCI5807704 Effective Dates: 1/1/2025-12/31/2025	BIN: 024202 PCN: CRX Group #: CDNSGW
Sedgwick: 1-877-246-3894	Cadence RX Help Desk: 1-877-776-3600

Section 2 – Employee Information (to be completed by Conservation Legacy participant)

Member/Participant Name: _____ Date of injury/onset: _____

CLAIM #: _____ Date of treatment: _____

Section 3 – Diagnosis (to be completed by treating provider)Brief description of injury/illness: _____
_____**Section 4 – Treatment (to be completed by treating provider)**

The job that this member was enrolled to complete generally requires bending, stooping, lifting up to 50 lbs., repetitive motions, hiking and spending extended periods of time outside. However, Conservation Legacy may modify duty opportunities for members/staff, regardless of their initial service agreement. If an injury requires adjustment of duties please indicate the appropriate level of modification.

- ☐ **No Physical Activity:** This member may not engage in modified, sedentary or regular field duties.
- ☐ **Modified/Light Duty for injured area- OFFICE:** Modified duty tasks requiring minimal physical ability. Member may alternate sitting or standing. May include: Indoor duties, assisting in maintaining files for the business and program departments; assisting in the assembly and/or creation of education materials; Inventory of gear, equipment and tools.
- ☐ **Modified/Light Duty for Injured Area- FIELD:** Modified duty tasks that are not utilizing the area of injury. Members may continue regular duties, excluding any that may further harm the area of injury, directly or indirectly. These injury areas include:.
- ☐ **Full Duty:** Treating provider is releasing participant to full duty with no exceptions. Participant agrees to follow treatment plan (i.e. taking scheduled prescription medications, washing wounds regularly, attending follow-up visits, etc.).

Additional Treatment Notes: _____

_____**Section 5 - Follow-Up (to be completed by treating provider)**

- YES NO Participant needs to seek follow-up care in _____ days / weeks.
- YES NO Participant should be limited to light-duty for _____ days / weeks.
- YES NO Participant is cleared to return to full duty as of _____ (date) without follow-up.

Practitioner Signature: _____

Date: _____

Practitioner Name: _____

Title: _____

Provider Name & Address _____

Phone: _____