

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

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

Phone: \_\_\_\_\_