Work Status Form

Employee must return this form to Manager immediately after medical treatment.

Doctors: Please FAX this form to Manager @ <FAX Number>

1. Employee Information

Patient Name:	**Phone Number:** ( ) -
Employer:	**Social Security #:** - -

Injury Date/Time	**Date of Exam**	**Time In**	**Time Out**

Employee Authorization for Release of Medical Records

I, _____ authorize all medical personnel who have treated me, and their
Employee to Print Name Here
staff, to release medical records and to discuss my medical status and work ability with my employer and/or their representative, including representatives from the insurance company and claims administrator.

_____ _____
Employee Signature Date

2. Injury Type

Injury Type: ❑ New Injury ❑ No Injury/Illness Found ❑ Aggravation/Recurrence of Existing Injury

Exam Type: ❑ First Aid Only ❑ Initial Evaluation/Treatment ❑ Follow Up ❑ Consultation Only

❑ Other (specify): _____

Body Part(s) Injured:

Diagnosis:

3. Treatment

Medication(s):

Further Treatment Needed: ❑ Yes ❑ No ❑ As Needed Basis

Patient is Permanent and Stationary: ❑ Yes ❑ No

Permanent Disability Expected: ❑ Yes ❑ No ❑ Unknown

Note: This opinion is NOT binding as the patient's condition may improve or worsen in the future.

Treatment: ❑ Physical Therapy ❑ Hand Therapy ❑ Other (specify): _____

Testing: ❑ CT Scan ❑ MRI ❑ EMG ❑ X-Ray ❑ Other (specify): _____

Testing Date/Time:	
Referred for Evaluation with:	**Clinic:**

4. Work Ability

Job Description Reviewed: ❑ Yes ❑ No	**Job Analysis Video Reviewed:** ❑ Yes ❑ No

Work Status: _____ ***Medical Provider Initials***

❑ Return to full duty with no restrictions on _____ (Date)

❑ Return to work with restrictions (see below) on _____ (Date) for _____ days

❑ Remain off duty until _____ (Date)

5. Physical Restrictions

Indicate restriction by checking box and entering limitation information (e.g. frequency, duration, weight, etc.)

Activity	***WORK Restrictions***	***HOME Restrictions***
Keyboarding/Typing	☐ Limitation:	☐ Limitation:
Squat/Kneel	☐ Limitation:	☐ Limitation:
Sit	☐ Limitation:	☐ Limitation:
Drive	☐ Limitation:	☐ Limitation:
Stand	☐ Limitation:	☐ Limitation:
Walk	☐ Limitation:	☐ Limitation:
Bend	☐ Limitation:	☐ Limitation:
Stoop	☐ Limitation:	☐ Limitation:
Climb Ladders	☐ Limitation:	☐ Limitation:
Climb Stairs	☐ Limitation:	☐ Limitation:
Push/Pull	☐ Limitation:	☐ Limitation:
Grip/Grasp	☐ Limitation:	☐ Limitation:

Twist	☐ Limitation:	☐ Limitation:
Reach Overhead	☐ Limitation:	☐ Limitation:
Use Machinery	☐ Limitation:	☐ Limitation:
Lift	☐ Limitation: ❑ 0 – 10 lbs ❑ 11 – 25 lbs ❑ 26 – 40 lbs ❑ More than 40 lbs	☐ Limitation: ❑ 0 – 10 lbs ❑ 11 – 25 lbs ❑ 26 – 40 lbs ❑ More than 40 lbs
Carry	☐ Limitation: ❑ 0 – 10 lbs ❑ 11 – 25 lbs ❑ 26 – 40 lbs ❑ More than 40 lbs	☐ Limitation: ❑ 0 – 10 lbs ❑ 11 – 25 lbs ❑ 26 – 40 lbs ❑ More than 40 lbs

Assistive Device(s) Required: ❑ Yes ❑ No

Type:	**Length of Time:**

Environmental (i.e. avoid dust, etc.):

Other Precautions:

6. Next Appointment

Comments

Next Appointment Date/Time:	**Clinic:**

7. Medical Provider Signature

The contents of this report are true and correct to the best of my knowledge.

Medical Provider Name	Signature	Date

Clinic Name	**Phone Number** **( ) -**