

# PHYSICIAN'S REPORT / EMPLOYEE WORK STATUS

Physician: Please ensure that the employee receives a copy of this form and/or that it is faxed to employer.

EMPLOYEE NAME: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ FAX: \_\_\_\_\_

DX: \_\_\_\_\_

WORK RELATED:  NOT WORK RELATED:  UNDETERMINED:

RX: \_\_\_\_\_

PHYSICAL THERAPY AT: \_\_\_\_\_ FREQUENCY: \_\_\_\_\_ DURATION: \_\_\_\_\_

RETURN TO WORK REGULAR DUTY: \_\_\_/\_\_\_/\_\_\_ (Date) MMI: YES  NO  \_\_\_/\_\_\_/\_\_\_ (Date) PPD \_\_\_%

RETURN TO RESTRICTED WORK: \_\_\_/\_\_\_/\_\_\_ (Date) TO: \_\_\_/\_\_\_/\_\_\_ (Date)

**EMPLOYEE CAN:**                      NEVER                      OCCASIONAL                      FREQUENT                      CONTINUOUS

LIFT/CARRY: 0 TO 10#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 TO 25#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26 TO 35#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36 TO 50#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 TO 75#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76 TO 100#	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REACH ABOVE SHOULDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PUSH/PULL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SQUAT/KNEEL/STOOP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BENDING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CAN USE L/R HAND FOR				
SIMPLE GRASPING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FIRM GRASPING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FINE MANIPULATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TORQUING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>KEY:</b>	
OCCASIONAL	- UP TO 33%
FREQUENT	- 34 TO 66%
CONTINUOUS	- 67 TO 100%

WORK HOURS: \_\_\_\_\_ FULL SHIFT \_\_\_\_\_ PARTIAL SHIFT OR \_\_\_\_\_ HRS/DAY (RESTRICTED)

(NO. OF HOURS/DAY) \_\_\_\_\_ SITTING \_\_\_\_\_ STANDING \_\_\_\_\_ WALKING

MODIFICATIONS APPLY TO: \_\_\_\_\_ WORK \_\_\_\_\_ HOME \_\_\_\_\_ LEISURE

**THIS PATIENT'S EMPLOYER HAS A "RETURN-TO-WORK PROGRAM" AND IS COMMITTED TO PROVIDING WORK WITHIN ANY RESTRICTIONS**

UNABLE TO WORK FROM: \_\_\_/\_\_\_/\_\_\_ (Date) TO \_\_\_/\_\_\_/\_\_\_ (Date)

ADDITIONAL COMMENTS: \_\_\_\_\_

RETURN TO CLINIC ON: \_\_\_/\_\_\_/\_\_\_ (Date)

REFERRAL TO: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(PRINTED NAME): \_\_\_\_\_ CLINIC: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_