

**PHYSICIANS WORKERS' STATUS REPORT**

For Employees of The State of Connecticut

PER-WC-208 REV. 12/14

**State of Connecticut  
Department of Administrative Services  
Workers' Compensation Division**

**INSTRUCTIONS**

- To be completed by initial care or attending physician and provided to the injured worker as part of the office visit.
- Mail or fax copy to State of Connecticut Third Party Claim Administration Company within 24 hours of the office visit.

- Gallagher Bassett Services, Inc., 55 Hartland St., Suite 400, East Hartford, Connecticut 06108  
 Fax: (860) 291-9875  
 Phone: (860) 256-3400

To be Completed By Initial Care Physician or Attending Physician

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Employee Name	Social Security Number	State Agency
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Division	Facility	Address
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Date of Office Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_      Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_      (Circle) Initial Visit      Follow-Up Visit

Diagnosis: \_\_\_\_\_

Treatment Plan: \_\_\_\_\_

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Evidence of pre-existing condition: Yes  No       Injury/Illness casually related to worker's employment: Yes  No

**Patient work disposition (Please check the appropriate work disposition)**

- \_\_\_\_ Patient is capable of full and regular duty.
- \_\_\_\_ Patient is not capable of any form of work.
- \_\_\_\_ Patient is capable of modified/restricted work as indicated below

**Note: In terms of a normal work day; Occasionally = Up to 33%, Frequently = Up to 66%, and Continuously = Up to 100%**

	Never	Occ.	Freq.	Cont.	No Restrictions
a. Patient is able to:					
Bend	_____	_____	_____	_____	_____
Squat	_____	_____	_____	_____	_____
Kneel	_____	_____	_____	_____	_____
Stand	_____	_____	_____	_____	_____
Walk	_____	_____	_____	_____	_____
Climb Stairs	_____	_____	_____	_____	_____
Twist	_____	_____	_____	_____	_____
Rotate	_____	_____	_____	_____	_____
Push/Pull	_____	_____	_____	_____	_____
Lift above shoulder	_____	_____	_____	_____	_____
Reach above shoulder	_____	_____	_____	_____	_____

	Never	Occ.	Freq.	Cont.	No Restrictions
b. Patient is able to lift					
Up to 10lbs	_____	_____	_____	_____	_____
11-24lbs	_____	_____	_____	_____	_____
25-34lbs	_____	_____	_____	_____	_____
35-50lbs	_____	_____	_____	_____	_____
51-74lbs	_____	_____	_____	_____	_____
75-100lbs	_____	_____	_____	_____	_____

	Never	Occ.	Freq.	Cont.	No Restrictions
c. Patient is able to carry					
Up to 10lbs	_____	_____	_____	_____	_____
11-24lbs	_____	_____	_____	_____	_____
25-34lbs	_____	_____	_____	_____	_____
35-50lbs	_____	_____	_____	_____	_____
51-74lbs	_____	_____	_____	_____	_____
75-100lbs	_____	_____	_____	_____	_____

	Never	Occ.	Freq.	Cont.	No Restrictions
d. Patient is able to use hands					
Keyboard Typing	_____	_____	_____	_____	_____
Grasping	_____	_____	_____	_____	_____

e. Is patient involved with treatment and/or medication that might affect his/her ability to work?  
 No  
 Yes: Explanation: \_\_\_\_\_

f. Will patient be required to use any assistive devices or braces while working regular or modified/restricted duty?  
 No  
 Yes: Explanation: \_\_\_\_\_

Physician Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The restrictions are in effect until: \_\_\_\_/\_\_\_\_/\_\_\_\_ Next appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Physician: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Please Print

**ARRIVED:** \_\_\_\_\_  
**DEPARTED:** \_\_\_\_\_  
**TRAVEL:** \_\_\_\_\_

**Authorization to Release Information**

**I hereby authorize this Medical Provider to release my information acquired in the course of my examination or treatment for the above injury to my employer or it's representative.**

\_\_\_\_\_  
**Patient's Name (Print)**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**