Workers' Compensation — Employee Medical & Work Status Form

Rev. 9-26-2011

To Be Completed by Attending Physician/Office

Give a copy to employee at time of visit ■ File a copy in medical file
Fax a copy to carrier, TPA, employer, or designee within one business day of visit

Employee Name: _____ Date of Birth: ____ / ____ / ____
(last) (first) (middle)

Employer Name: _____ Department/Division: _____

Employer Address/Location: _____

Initial or *Follow-Up* Visit (circle one) Payer/Managed Care Plan Name: _____ Claim#: _____

Date of Injury/Illness: ____ / ____ / ____ Date of this visit: ____ / ____ / ____ ☐ Employee will be seen in this office for

Employee's job (as stated by employee): _____ follow-up on ____ / ____ / ____ .

WORK STATUS - Having evaluated/treated this employee today, in my opinion:

☐ Employee may continue regular work duty. ☐ There is no change from prior visit.

☐ Employee may return to his/her regular work on ____ / ____ / ____ without restriction.

☐ Employee can return to work on ____ / ____ / ____ with the **following functional capabilities**: In an 8-hour workday, employee may:

	1-2 hours	2-4 hours	4-6 hours	6-8 hours	None
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Bend/Squat	☐	☐	☐	☐	☐
Climb	☐	☐	☐	☐	☐
Reach	☐	☐	☐	☐	☐
Twist	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐
Drive	☐	☐	☐	☐	☐
Foot/Feet	☐	☐	☐	☐	☐
Hand(s)	☐	☐	☐	☐	☐

☐ Patient is able to lift ☐ Patient is **unable to lift greater than** _____ **pounds.**

Patient may use ☐ RIGHT ☐ LEFT ☐ BOTH foot/feet for repetitive movement as in operating foot controls.

Patient may use ☐ RIGHT ☐ LEFT ☐ BOTH hands for repetitive ☐ single grasping ☐ fine manipulation ☐ pushing and pulling.

The restrictions noted above are in effect until ____ / ____ / ____.

☐ Employee is Temporarily Totally Disabled until ____ / ____ / ____ or pending recheck here on ____ / ____ / ____.

☐ Employee is on medication that will restrict his/her ability to work safely. Explain: _____

I HAVE DISCUSSED THIS PATIENT'S WORK RESTRICTIONS TELEPHONICALLY TODAY WITH HIS/HER EMPLOYER'S REPRESENTATIVE, OR HAVE COMPLETED THE EMPLOYER'S WORK STATUS FORM IN LIEU OF COMPLETING THE RESTRICTION PORTION OF THIS FORM. RELEASE TO REGULAR DUTY WITHOUT RESTRICTIONS AND/OR TOTAL DISABILITY MUST BE DOCUMENTED USING THIS FORM OR THE EMPLOYER'S STANDARD FORM.

DIAGNOSIS: _____ **TREATMENT PLAN:** _____

Provider Name (print): _____ Provider Address: _____

Provider Signature: _____ Date: ____ / ____ / ____

I have received a copy of this document—Employee Signature: _____ Date: ____ / ____ / ____