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: _____ / _____ / _____