WORK STATUS REPORT

IMPORTANT

INFORMATION ON INJURED WORKER

Date of visit:	SS No:	Claim Number:
Name:	Address:	City/St/Zip:
Phone:	Date of injury:	Birth Date:
Employer's Name:	Claims Administrator:	Nurse Case Manager:

WORK STATUS

PLEASE DO NOT AUTHORIZE TIME OFF FROM WORK WITHOUT NOTIFYING THE NURSE CARE MANAGER.
MODIFIED DUTY AVAILABLE; JOB DESCRIPTIONS PROVIDED UPON REQUEST.

MAY RETURN TO WORK: Full Duty ☐ Restricted Duty ☐ No Work ☐ * Estimated time off ☐

* **IF "NO WORK" BOX CHECKED, PROVIDE THE FOLLOWING ADDITIONAL INFORMATION AS TO WHY THE INJURED WORKER CANNOT PERFORM ANY WORK DUTIES:**

- ☐ **BEDBOUND/HOMEBOUND REQUIRING TAXING EFFORT TO LEAVE HOME/UNSAFE TO LEAVE HOME**
- ☐ **THE INJURED WORKER IS WITHIN ☐ DAYS OF SURGERY**
- ☐ **UNABLE TO PERFORM ACTIVITIES OF DAILY LIVING AT HOME OR AT WORK**
- ☐ **OTHER CIRCUMSTANCES – PLEASE GIVE EXPLANATION**

NARRATIVE TO FOLLOW BY (DATE): ☐

RESTRICTIONS (**apply at home as well as work**):

LIFTING/CARRYING:
- ☐ Minimal (0-5 lbs)
- ☐ Light (5-15 lbs)
- ☐ Moderate (15-50 lbs)
- ☐ Heavy (50+ lbs)

BENDING/STOOPING:
- ☐ Light (0-6 times/hr)
- ☐ Moderate (6-10 times/hr)
- ☐ Heavy (10+ times/hr)

PUSHING/PULLING:
- ☐ Light (10-25 lbs)
- ☐ Moderate (25-50 lbs)
- ☐ Heavy (50+ lbs)

CLIMBING:
- ☐ No vertical ladders
- ☐ No stairs
- ☐ No ramps

NO WORK INVOLVING:
- Hand Bil ☐ R ☐ L ☐
- Arm Bil ☐ R ☐ L ☐
- Leg Bil ☐ R ☐ L ☐
- ☐ WEAR SPLINT/BRACE/CAST
- ☐ SITTING JOB ONLY – Sit for at a time
- ☐ STANDING JOB ONLY – Stand for at a time
- ☐ SQUAT FOR at a time
- ☐ REPETITIVE TASKS FOR at a time
- ☐ TWIST times per hour
- ☐ NO USE OF VIBRATORY TOOLS or GUNS
- ☐ NO OVERHEAD WORK AT OR ABOVE 90°
- ☐ NOT TO OPERATE MOVING MACHINERY
- ☐ NOT TO GET ON/OFF MOVING EQUIPMENT
- ☐ NO DRIVING
- ☐ OTHER:

CLARIFICATION OF RESTRICTIONS:

DURATION OF RESTRICTIONS: NEXT APPOINTMENT DATE:

THIS PATIENT HAS REACHED MAXIMUM MEDICAL IMPROVEMENT: YES ☐ NO ☐ DATE OF DISCHARGE FROM CARE:

ACTIVITIES PATIENT **SHOULD** PERFORM TO HASTEN HEALING:

OTHER COMMENTS:

PROVIDER NAME PHONE FAX

ADDRESS

PROVIDER SIGNATURE DATE

Please fax or mail to the Employer, Claims Administrator, and/or Nurse Case Manager.
Report is eligible for reimbursement under California's OMFS – bill Code 99081. 9/2010