# Work Status Form

*(Instructions: Return this completed form to employee)*

|  |  |  |  |
| --- | --- | --- | --- |
| Employee’s Last Name | Employee’s First Name | Date of Appointment |  |

* Employee is released to return to Regular Work on (date)
* Employee is released to Transitional (Modified) Work from (date) until (date)

**Employee May:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | No restrictions | Total hours during day | Hours at one time |
|  |  | 8+ | 6-8 | 4-6 | 2-4 | 0-2 | 8+ | 6-8 | 4-6 | 2-4 | 0-2 |
| □ Stand/Walk | □ |  |  |  |  |  |  |  |  |  |  |
| □ Sit | □ |  |  |  |  |  |  |  |  |  |  |
| □ Drive | □ |  |  |  |  |  |  |  |  |  |  |
| □ Bend | □ |  |  |  |  |  |  |  |  |  |  |
| □ Squat | □ |  |  |  |  |  |  |  |  |  |  |
| □ Kneel | □ |  |  |  |  |  |  |  |  |  |  |
| □ Climb | □ |  |  |  |  |  |  |  |  |  |  |
| □ Twist | □ |  |  |  |  |  |  |  |  |  |  |
| □ Crawl | □ |  |  |  |  |  |  |  |  |  |  |
| □ Reach | □ |  |  |  |  |  |  |  |  |  |  |
| □ right hand | □ |  |  |  |  |  |  |  |  |  |  |
| □ left hand | □ |  |  |  |  |  |  |  |  |  |  |
| □ overhead | □ |  |  |  |  |  |  |  |  |  |  |
| □ Grasp | □ |  |  |  |  |  |  |  |  |  |  |
| □ right hand | □ |  |  |  |  |  |  |  |  |  |  |
| □ left hand | □ |  |  |  |  |  |  |  |  |  |  |
| □ Fine Manipulation | □ |  |  |  |  |  |  |  |  |  |  |
| □ right hand | □ |  |  |  |  |  |  |  |  |  |  |
| □ left hand | □ |  |  |  |  |  |  |  |  |  |  |
| □ Use Keyboard | □ |  |  |  |  |  |  |  |  |  |  |
| □ Push/Pull | □ |  |  |  |  |  |  |  |  |  |  |
| □ right hand | □ |  |  |  |  |  |  |  |  |  |  |
| □ left hand | □ |  |  |  |  |  |  |  |  |  |  |
| □ Lift lbs | □ |  |  |  |  |  |  |  |  |  |  |
| □ Carry lbs | □ |  |  |  |  |  |  |  |  |  |  |

* Number of hours able to work per day if less than full time
* Is employee restricted by environmental factors, such as heat/cold, dust, dampness, heights, chemicals, fumes, gases, odors, noise, vibration, etc.?

□ No □ Yes, please explain

* Other instructions/restrictions/comments

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Provider Signature Provider Name (print) and Phone # Date