DEPARTMENT OF LABOR AND INDSTRY (DLI) MEDICAL STATUS FORM[1] (VERSION 1, PUBLISHED xx/xx/25)
COMPLETE ONE VERSION OF THE MEDICAL STATUS FORM PER VISIT, AS PER MCA 39-71-1036

EMPLOYEE/PROVIDER INFORMATION (1)	EMPLOYEE NAME	DATE OF BIRTH (mm/dd/yy)	PROVIDER NAME, LOCATION, PHONE
	CLAIM NUMBER AND DATE OF INJURY (mm/dd/yy)	INJURED BODY PART FOR RESTRICTIONS	CURRENT EMPLOYER

WORK CAPACITY (2)	**CURRENT WORK CAPACITY**	**EXPECTED DURATION OF CURRENT WORK CAPACITY** *Applies to all settings (e.g., home and work)*	
	RELEASED TO FULL DUTY	From	To
	RELEASED TO MODIFIED DUTY ***Complete Section 3****	From	To
	EMPLOYEE MAY WORK LIMITED HOURS ____ HOURS PER DAY	From	To
	NOT RELEASED TO WORK	From	To

PROVIDER REQUESTS A COPY OF THE INJURED WORKER'S JOB DESCRIPTION: □ YES □ NO

INDIVIDUAL IS CAPABLE OF THE FOLLOWING ACTIVITIES: *No response = no restrictions*

MODIFIED WORK ABILITIES (3) *No response = no restrictions*

WORKER IS CAPABLE OF THE FOLLOWING *No response = no restrictions*	Continuous ≥ 67% (Not restricted)	Frequent 34-66% (3-6 hours)	Occasional 11-33% (1-3 hours)	Seldom 1-10% (0-1 hour)	Never
Sit					
Stand					
Walk					
Drive					
Work from ladder					
Climb ladder or stairs					
Twist					
Bend/Stoop at waist					
Squat					
Kneel					
Crawl					
Pinch/Grip □ **L** □ **R** □ **B**					
Reach in front □ **L** □ **R** □ **B**					
Reach overhead □ **L** □ **R** □ **B**					
PLEASE INDICATE WHETHER THE FOLLOWING WEIGHT AND FREQUENCY RESTRICTIONS BELOW REFER TO **L**EFT, **R**IGHT,**B**OTH					
Lifting □ **L** □ **R** □ **B**	lbs	lbs	lbs	lbs	lbs
Carrying □ **L** □ **R** □ **B**	lbs	lbs	lbs	lbs	lbs
Pushing/pulling □ **L** □ **R** □ **B**	lbs	lbs	lbs	lbs	lbs

Notes on information above:

WORK STATUS
□ Anticipated time to a trial of full duty work: _____ □ Not applicable, already full duty

MAXIMUM MEDICAL IMPROVEMENT (MMI) AND IMPAIRMENT RATING STATUS
□ Injured worker has reached MMI Date: _____
□ Injured worker is not at MMI, but is anticipated to be at MMI in/on: _____ (date or duration)
□ Request independent medical evaluation (IME) □ Request impairment rating (IR)

FOLLOW UP
□ Injured worker will return to clinic: _____ (date or weeks out) □ Injured worker will return, as needed

TREATING PHYSICIAN OR DESIGNEE[2]
SIGNATURE: _____ DATE: _____
PRINT: _____ DATE: _____

[1]This form meets the minimum statutory requirements, as per MCA 39-71-1036.
[2]Treating physician, as defined in MCA 39-71-116, and completion of the medical status form, per MCA 39-71-1036.

DEPARTMENT OF LABOR AND INDSTRY (DLI) MEDICAL STATUS FORM[1] (VERSION 2, PUBLISHED xx/xx/25)
COMPLETE ONE VERSION OF THE MEDICAL STATUS FORM PER VISIT, AS PER MCA 39-71-1036

EMPLOYEE/PROVIDER INFORMATION (1)	EMPLOYEE NAME	DATE OF BIRTH (mm/dd/yy)	PROVIDER NAME, LOCATION, PHONE
	CLAIM NUMBER AND DATE OF INJURY (mm/dd/yy)	INJURED BODY PART FOR RESTRICTIONS	CURRENT EMPLOYER

WORK CAPACITY (2)	**CURRENT WORK CAPACITY**	**EXPECTED DURATION OF CURRENT WORK CAPACITY** *Applies to all settings (e.g., home and work)*	
	RELEASED TO FULL DUTY	From	To
	RELEASED TO MODIFIED DUTY ***Complete Section 3****	From	To
	EMPLOYEE MAY WORK LIMITED HOURS ____ HOURS PER DAY	From	To
	NOT RELEASED TO WORK	From	To

MODIFIED WORK ABILITIES (3)	**PROVIDER REQUESTS A COPY OF THE INJURED WORKER'S JOB DESCRIPTION:** □ YES □ NO		
	INDIVIDUAL IS CAPABLE OF THE FOLLOWING ACTIVITIES: *No response = no restrictions*		
	ACTIVITY BY HOURS PER DAY *Indicate Left, Right, or Both, when applicable*		
	SIT	_____ hours per day	
	STAND	_____ hours per day	
	WALK	_____ hours per day	
	DRIVE		
	WORK FROM LADDER		
	CLIMB LADDER OR STAIRS		
	CRAWL	_____ hours per day	
	KNEEL	_____ hours per day	
	SQUAT	_____ hours per day	
	PINCH/GRIP □ **L** □ **R** □ **B**	_____ hours per day	
	Notes on information above:		
	CAN THE INJURED WORKER SAFELY: *Indicate Left, Right, or Both, when applicable*		
		MARK RESPONSE	
	TWIST AT TRUNK	□ YES	□ NO
	BEND/STOOP AT WAIST	□ YES	□ NO
	OPERATE HEAVY EQUIPMENT/DRIVE	□ YES	□ NO
	REACH IN FRONT □ **L** □ **R** □ **B**	□ YES	□ NO
	REACH OVERHEAD □ **L** □ **R** □ **B**	□ YES	□ NO
	Notes on information above:		
	INDICATE SAFE WEIGHT CAPACITY BELOW *Indicate Left, Right, or Both, when applicable*		
	LIFTING □ **L** □ **R** □ **B**	_____ pounds	
	CARRYING □ **L** □ **R** □ **B**	_____ pounds	
	PUSHING/PULLING □ **L** □ **R** □ **B**	_____ pounds	
	Notes on information above:		

WORK STATUS
Anticipated time to a trial of full duty work: _____ □ Not applicable, already released to full duty

MAXIMUM MEDICAL IMPROVEMENT (MMI) AND IMPAIRMENT RATING STATUS
□ Injured worker has reached MMI Date: _____
□ Injured worker is not at MMI, but is anticipated to be at MMI in/on: _____ (date or duration)
□ Request independent medical evaluation (IME) □ Request impairment rating (IR)

FOLLOW UP
□ Injured worker will return to clinic: _____ (date or weeks out) □ Injured worker will return to clinic, as needed

TREATING PHYSICIAN OR DESIGNEE[2]
SIGNATURE _____ DATE: _____
PRINT: _____ DATE: _____

[1]This form meets the minimum statutory requirements, as per MCA 39-71-1036.
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DEPARTMENT OF LABOR AND INDSTRY (DLI) MEDICAL STATUS FORM[1] (VERSION 3, PUBLISHED xx/xx/25)
COMPLETE ONE VERSION OF THE MEDICAL STATUS FORM PER VISIT, AS PER MCA 39-71-1036

EMPLOYEE/PROVIDER INFORMATION (1)			
	EMPLOYEE NAME	DATE OF BIRTH (mm/dd/yy)	PROVIDER NAME, CLINIC LOCATION, PHONE
	CLAIM NUMBER AND DATE OF INJURY (MM/DD/YY)	INJURED BODY PART FOR RESTRICTIONS	CURRENT EMPLOYER

WORK CAPACITY (2)	**CURRENT WORK CAPACITY**	**EXPECTED DURATION OF CURRENT WORK CAPACITY** *Capacities apply to all settings (e.g., home and work)*	
	RELEASED TO FULL DUTY	From	To
	RELEASED TO MODIFIED DUTY* ***Complete Section 3****	From	To
	EMPLOYEE MAY WORK LIMITED HOURS ____ HOURS PER DAY	From	To
	NOT RELEASED TO WORK	From	To

MODIFIED WORK ABILITIES (3)
No response = no restrictions

PROVIDER REQUESTS A COPY OF THE INJURED WORKER'S JOB DESCRIPTION: □ YES □ NO

PROVIDE A LEVEL OF DETAIL* THAT WILL ALLOW THE EMPLOYER TO SAFELY ACCOMMODATE THE INJURED WORKER IN THE WORKPLACE. CONSIDER RESTRICTIONS IN TERMS OF ALL OF THE FOLLOWING ELEMENTS
Restrictions should be based on the injured worker's capacity and focused on reducing the medical risk of re-injury.

INDIVIDUAL IS CAPABLE OF THE FOLLOWING ACTIVITIES *No response = no restrictions*

Specific Activities, Including Frequency/Duration
Consider sit, stand, walk, crawl, kneel, squat, climb, pinch/grip, reach, drive, operate heavy equipment, etc.
Please consider each activity in terms of times/hour or hours/day

Force *(Comment on lifting, carrying, pushing, pulling, considering weights and frequencies of activity* ***or*** *complete the table below)*

	Continuous ≥ 67% (Not restricted)	Frequent 34-66% (3-6 hours)	Occasional 11-33% (1-3 hours)	Seldom 1-10% (0-1 hour)	Never
Lifting □ **L** □ **R** □ **B**	lbs	lbs	lbs	lbs	lbs
Carrying □ **L** □ **R** □ **B**	lbs	lbs	lbs	lbs	lbs
Pushing/pulling □ **L** □ **R** □ **B**	lbs	lbs	lbs	lbs	lbs

**Examples of temporary restrictions, pending follow up evaluation:*
Low back sprain: Alternate sit/stand/walk activities, no stooping, maximum lift/carry of 20 pounds.
Right shoulder rotator cuff tear: Maximum bilateral lift below waist of 20 pounds, above waist of 10 pounds.
Cervical sprain with muscle relaxer/sedating medication: No driving or safety sensitive tasks.

WORK STATUS
Anticipated time to a trial of full duty work: _____ □ Not applicable, already released to full duty

MAXIMUM MEDICAL IMPROVEMENT (MMI) AND IMPAIRMENT RATING STATUS
□ Injured worker has reached MMI Date: _____
□ Injured worker is not at MMI, but is anticipated to be at MMI in/on: _____ (date or duration)
□ Request independent medical evaluation (IME) □ Request impairment rating (IR)

FOLLOW UP
□ Injured worker will return to clinic: _____ (date or weeks out)
□ Injured worker will return to clinic, as needed

TREATING PHYSICIAN OR DESIGNEE[2]
SIGNATURE _____ DATE: _____
PRINT: _____ DATE: _____

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