WORK STATUS FORM – DRAFT TEMPLATES

(1) /PRO IN EMPL	EMPLOYEE NAME	DATE OF BIRTH (mm/dd/yy)	PROVIDER CLINIC LOCATION
	CLAIM NUMBER	DATE OF INJURY (mm/dd/yy)	PROVIDER CLINIC PHONE

WORK CA	**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
	NOT RELEASED TO WORK	From	To

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

INJURED BODY PART TO WHICH RESTRICTIONS APPLY:

MODI

WORKER IS CAPABLE OF THE FOLLOWING *Blank space = 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					
Squat/Kneel					
Crawl					
PLEASE INDICATE WHETHER THE FOLLOWING RESTRICTIONS REFER TO **L**EFT, **R**IGHT, OR **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
Pinching/Gripping **L R B**					
Reach **L R B**					
Reaching overhead **L R B**					

Notes on information above:

The restrictions noted above are: □ Temporary □ Permanent

Would you like to review a copy of the injured worker's job description: □ YES □ NO

WORK STATUS

Anticipated release to, or trial of, full duty work: _____

MAXIMUM MEDICAL IMPROVEMENT 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)

FOLLOW UP

Injured worker will return to clinic: _____ (date or weeks out)

PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____ DATE: _____

WORK STATUS FORM – DRAFT TEMPLATES

(1)	EMPLOYEE NAME:	DATE OF BIRTH (mm/dd/yy)	PROVIDER CLINIC LOCATION
EMPL INI	CLAIM NUMBER:	DATE OF INJURY (mm/dd/yy)	PROVIDER PHONE

WORI CA	**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
	NOT RELEASED TO WORK	From	To

MODI	**INDIVIDUAL IS CAPABLE OF THE FOLLOWING ACTIVITIES:** *No response = no restrictions*		
	INJURED BODY PART TO WHICH RESTRICTIONS APPLY:		
	ACTIVITY BY HOURS PER DAY *Indicate Left, Right, or Both, when applicable*		
	SIT (INCLUDES DRIVING)	_____ hours per day	
	STAND	_____ hours per day	
	WALK	_____ hours per day	
	CRAWL	_____ hours per day	
	KNEEL	_____ hours per day	
	SQUAT	_____ hours per day	
	CLIMB	_____ hours per day	
	PINCH/GRIP **L R B**		
	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 **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	_____ pounds	
	CARRYING **L R B**	_____ pounds	
	PUSHING/PULLING **L R B**	_____ pounds	
	Notes on information above:		
The restrictions noted above are □ Temporary □ Permanent			
Would you like to review a copy of the injured worker's job description: □ YES □ NO			

WORK STATUS

Anticipated release to or trial of full duty work: _____

MAXIMUM MEDICAL IMPROVEMENT 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)

FOLLOW UP

Injured worker will return to clinic: _____ (date or weeks out)

PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____ DATE: _____

WORK STATUS FORM – DRAFT TEMPLATES

/PRO	EMPLOYEE NAME:	DATE OF BIRTH (mm/dd/yy)	PROVIDER NAME
IN EMPL	CLAIM NUMBER:	DATE OF INJURY (mm/dd/yy)	PROVIDER PHONE

(2) WORK CA	**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
	NOT RELEASED TO WORK	From	To

	INDIVIDUAL IS CAPABLE OF THE FOLLOWING ACTIVITIES: *No response = no restrictions*
	INJURED BODY PART TO WHICH RESTRICTIONS APPLY:
(3) MODI	*Provide a level of detail* that will allow the employer to safely accommodate the injured worker in the workplace. Consider restrictions in terms of* - ***specific activities*** *(e.g., sit, stand, walk, crawl, kneel, squat, climb, pinch/grip, reach, drive, operate heavy equipment), and* - ***frequency*** *(times/hour), and* - ***duration*** *(hours/day), sidedness (e.g., left, or right), and* - ***force*** *(lifting, carrying, pushing, pulling).* *Restrictions should be based on injured worker's capacity to reduce risk of re-injury.* **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.*
The restrictions noted above are □ Temporary □ Permanent	
Would you like to review a copy of the injured worker's job description: □ YES □ NO	

WORK STATUS
Anticipated release to or trial of full duty work: _____

MAXIMUM MEDICAL IMPROVEMENT 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)

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

PROVIDER SIGNATURE: _____ DATE: _____
PRINT NAME: _____ DATE: _____