DEPARTMENT OF LABOR AND INDSTRY (DLI) MEDICAL STATUS FORM[1] (VERSION 1, EFFECTIVE 01/10/26)
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: *Indicate **L**eft, **R**ight, or **B**oth, when applicable*

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					
Operate heavy equipment/drive					
Work from ladder					
Climb ladder or stairs					
Crawl					
Kneel					
Squat					
Bend/stoop at waist					
Twist at trunk					
Pinch/grip ☐L ☐R ☐B					
Reach in front ☐L ☐R ☐B					
Reach overhead ☐L ☐R ☐B					
INDICATE SAFE WEIGHT AND FREQUENCY CAPACITY BELOW *Indicate **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

Notes on information above:

STATUS UPDATES (4)

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.