

DEPARTMENT OF LABOR AND INDSTRY (DLI) MEDICAL STATUS FORM¹ (VERSION 2, 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 <i>Applies to all settings (e.g., home and work)</i>	
	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: <i>No response = no restrictions</i>		
	ACTIVITY BY HOURS PER DAY		
	Sit	hours per day	
	Stand	hours per day	
	Walk	hours per day	
	Operate heavy equipment/drive	hours per day	
	Notes on information above:		
	CAN THE INJURED WORKER SAFELY: <i>Indicate Left, Right, or Both, when applicable</i>		
		MARK RESPONSE	
	Work from a ladder	yes	no
	Climb ladder or stairs	yes	no
	Crawl	yes	no
	Kneel	yes	no
	Squat	yes	no
	Bend/stoop at waist	yes	no
	Twist at trunk	yes	no
	Pinch/grip L R B	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 <i>Indicate Left, Right, or Both</i>			
Lifting L R B	pounds		
Carrying L R B	pounds		
Pushing/pulling L R B	pounds		
Notes on information above:			

STATUS UPDATES (4)

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 DESIGNEE²

SIGNATURE:

DATE:

PRINT:

DATE:

¹This form meets the minimum statutory requirements, as per MCA 39-71-1036.

²Treating physician, as defined in MCA 39-71-116, and completion of the medical status form, per MCA 39-71-1036.