

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 <i>*Complete Section 3*</i>	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: <i>No response = no restrictions</i> ACTIVITY BY HOURS PER DAY <table border="1"> <tr><td>Sit</td><td>hours per day</td></tr> <tr><td>Stand</td><td>hours per day</td></tr> <tr><td>Walk</td><td>hours per day</td></tr> <tr><td>Operate heavy equipment/drive</td><td>hours per day</td></tr> </table> <p>Notes on information above:</p>				Sit	hours per day	Stand	hours per day	Walk	hours per day	Operate heavy equipment/drive	hours per day
Sit	hours per day										
Stand	hours per day										
Walk	hours per day										
Operate heavy equipment/drive	hours per day										
MODIFIED WORK ABILITIES (3)	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.