

UNIVERSITY OF MINNESOTA DULUTH

Work Status Report

| | |
|---------------------|--|
| Patient Name _____ | |
| Date of Birth _____ | ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD |
| History # _____ | Date of Injury/Illness _____ |

TO BE COMPLETED BY ATTENDING PHYSICIAN

DIAGNOSIS/CONDITION (Brief Explanation)

1. Recommend return to work with no restrictions on _____
2. Recommend off work until _____ Reason: _____
3. Recommend return to work on _____ with the following restrictions as outlined below.
- I saw and treated this patient on _____ and based on the above description of the patient's current medical problem, the employee can do the following: _____

CHECK ONLY AS RELATED TO ABOVE CONDITIONS

| | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|-------------------------------------|--|------------------------------------|--|--------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|----------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Sedentary Work. Lifting 10 lbs. maximum and occasionally lifting and/or carrying such articles as docket, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. | 1. In an 8 hour work day, patient may: <ul style="list-style-type: none"> a. Stand/Walk <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> 4-6 Hours</td> <td><input type="checkbox"/> ____ Hours</td> </tr> <tr> <td><input type="checkbox"/> 1-4 Hours</td> <td><input type="checkbox"/> 6-8 Hours</td> <td></td> </tr> </table> b. Sit <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> 1-3 Hours</td> <td><input type="checkbox"/> 3-5 Hours</td> <td><input type="checkbox"/> 5-8 Hours</td> </tr> </table> c. Drive <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> 1-3 Hours</td> <td><input type="checkbox"/> 3-5 Hours</td> <td><input type="checkbox"/> 5-8 Hours</td> </tr> </table> | <input type="checkbox"/> None | <input type="checkbox"/> 4-6 Hours | <input type="checkbox"/> ____ Hours | <input type="checkbox"/> 1-4 Hours | <input type="checkbox"/> 6-8 Hours | | <input type="checkbox"/> 1-3 Hours | <input type="checkbox"/> 3-5 Hours | <input type="checkbox"/> 5-8 Hours | <input type="checkbox"/> 1-3 Hours | <input type="checkbox"/> 3-5 Hours | <input type="checkbox"/> 5-8 Hours | | | | | | | | | | | | |
| <input type="checkbox"/> None | <input type="checkbox"/> 4-6 Hours | <input type="checkbox"/> ____ Hours | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> 1-4 Hours | <input type="checkbox"/> 6-8 Hours | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> 1-3 Hours | <input type="checkbox"/> 3-5 Hours | <input type="checkbox"/> 5-8 Hours | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> 1-3 Hours | <input type="checkbox"/> 3-5 Hours | <input type="checkbox"/> 5-8 Hours | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Light Work. Lifting 20 lbs. maximum with frequent lifting and/or carrying objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job in this category may require walking or standing to a significant degree or may involve sitting most of the time with a degree of pushing and pulling of arm and/or leg controls. | 2. Patient may use hand(s) for repetitive: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Single Grasping</td> <td><input type="checkbox"/> Right Hand</td> </tr> <tr> <td><input type="checkbox"/> Pushing & Pulling</td> <td><input type="checkbox"/> Left Hand</td> </tr> <tr> <td><input type="checkbox"/> Fine Manipulation</td> <td></td> </tr> </table> | <input type="checkbox"/> Single Grasping | <input type="checkbox"/> Right Hand | <input type="checkbox"/> Pushing & Pulling | <input type="checkbox"/> Left Hand | <input type="checkbox"/> Fine Manipulation | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Single Grasping | <input type="checkbox"/> Right Hand | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Pushing & Pulling | <input type="checkbox"/> Left Hand | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Fine Manipulation | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Light Medium Work. Lifting 30 lbs. Maximum with frequent lifting and/or carrying of objects weighing up to 20 lbs. | 3. Patient may use foot/feet for repetitive movement as in operating foot/feet controls: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Medium Work. Lifting 50 lbs. Maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs. | 4. Patient may: <table style="width: 100%; border: none; margin-top: 10px;"> <tr> <td></td> <td style="text-align: center;">Not At All</td> <td style="text-align: center;">Occasionally</td> <td style="text-align: center;">Frequently</td> </tr> <tr> <td>a) Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b) Twist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c) Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d) Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e) Other</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> | | Not At All | Occasionally | Frequently | a) Bend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | b) Twist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | c) Squat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | d) Climb | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | e) Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not At All | Occasionally | Frequently | | | | | | | | | | | | | | | | | | | | | | |
| a) Bend | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| b) Twist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| c) Squat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| d) Climb | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| e) Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Heavy Work. Lifting 75 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 40 lbs. | 5. <input type="checkbox"/> No lifting above shoulder level. | | | | | | | | | | | | | | | | | | | | | | | | |

4. These restrictions are in effect until: _____

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| 5. Patient to be re-evaluated: _____ Days _____ Weeks _____ Date _____ Time | 6. Patient referred to: _____ Doctor |
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7. OTHER INSTRUCTIONS AND/OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS THAT MAY INTERFERE WITH WORK ACTIVITY.

| | |
|--|-------------|
| Physician's Signature: _____ Print Physician's Name Here: _____ Phone: _____ | Date: _____ |
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Not Filed as Workers' Compensation Claim

RETURN THIS FORM TO: UMD WORKERS' COMPENSATION COORDINATOR, DEPARTMENT OF HUMAN RESOURCES, UNIVERSITY OF MINNESOTA DULUTH, FAX: 218-726-7505. BY MAIL TO: 255 DARLAND ADMINISTRATION BUILDING, 10 UNIVERSITY DRIVE, DULUTH, MINNESOTA 55812-2496. TELEPHONE: 218-726-6827