WORK STATUS FORM

Name: _____ Employer: _____

Date: _____ Insurance Carrier: _____

Claim #: _____

Diagnosis:

☐ RTW without restrictions on_____

☐ Off work until _____ Permanent & Stationary

☐ Without restrictions, no future medical

RTW on_____ with the following restrictions: _____
_____

☐ Limited/ no use of right/left hand
☐ No heavy pushing or pulling, squeezing, gripping
☐ Pushing or pulling weight restriction:_____
☐ No reaching above shoulders
☐ No driving
☐ Sedentary work/ with limited walking
☐ No prolonged walking or standing
☐ Walking or standing restrictions: _____
☐ Weight lifting restrictions: _____
☐ No climbing, kneeling or squatting
☐ No REPETITIVE stooping/bending
☐ Use of brace
☐ Keep wound clean and dry
☐ Avoid exposure to solvent oils, dust or irritants
☐ Other_____

YOUR NEXT PHYSICIAN APPOINTMENT IS:

DATE: _____ TIME: _____

☐ You have been discharged from Medical Care

Physician Signature: Date:

_____ _____