HUMAN RESOURCES
TEXAS A&M UNIVERSITY

Early Return to Work Program – Work Status Report Form

HR Liaisons/Managers: This form is to be used only for injuries/illnesses that are NOT work-related. Provide an uncompleted copy of this form to the employee for them to provide to their physician.

Physician's Instructions: This form must be completed by a physician or practitioner. The **Genetic Information Nondiscrimination Act of 2008** (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees of their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PART I: GENERAL INFORMATION	4. Doctor's Name
1. Employee's Name	5. Clinic/Facility Name
2. Date of Injury or illness	6. Clinic/Facility/Doctor Phone & Fax
3. Medical facts of condition	7. Clinic/Facility/Doctor Address (street address)
	8. City State Zip

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN PART III AS APPLICABLE)

9. The injured employee's medical condition resulting from the injury or illness:

☐ (a) will allow the employee **to return to work** as of _____ (date) **without restrictions**.

☐ (b) will allow the employee **to return to work** as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

☐ (c) has prevented and still prevents the **employee from returning to work** as of _____ (date) and is expected to continue through _____ (date). The following describes how this injury **prevents the employee from returning to work:**

PART III: ACTIVITY RESTRICTIONS* (REQUIRED IF PART II (b) IS CHECKED)

10. POSTURE RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	_____
Sitting	☐	☐	☐	☐	☐	_____
Kneeling/Squatting	☐	☐	☐	☐	☐	_____
Bending/Stooping	☐	☐	☐	☐	☐	_____
Pushing/Pulling	☐	☐	☐	☐	☐	_____
Twisting	☐	☐	☐	☐	☐	_____
Other: _____	☐	☐	☐	☐	☐	_____

11. RESTRICTIONS SPECIFIC TO (if applicable):

☐ L Hand/Wrist ☐ R Hand/Wrist

☐ L Arm ☐ R Arm ☐ Neck

☐ L Leg ☐ R Leg ☐ Back

☐ L Foot/Ankle ☐ R Foot/Ankle

☐ Other: _____

13. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	_____
Climbing stairs/ladders	☐	☐	☐	☐	☐	_____
Grasping/Squeezing	☐	☐	☐	☐	☐	_____
Wrist flexion/extension	☐	☐	☐	☐	☐	_____
Reaching	☐	☐	☐	☐	☐	_____
Overhead Reaching	☐	☐	☐	☐	☐	_____
Keyboarding	☐	☐	☐	☐	☐	_____
Other: _____	☐	☐	☐	☐	☐	_____

14. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than _____ lbs. for lbs..

for more than ____ hours per day

☐ May not perform any lifting/carrying

☐ Other: _____

15. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work: _____

☐ Sit/Stretch breaks of _____ per _____

☐ Must wear splint/cast at work

☐ Must use crutches at all times

☐ No driving/operating heavy equipment

☐ Can only drive automatic transmission

☐ No work / ☐ _____ hours/day work:

☐ in extreme hot/cold environments

☐ at heights or on scaffolding

☐ Must keep _____:

☐ Elevated ☐ Clean & Dry

☐ No skin contact with: _____

☐ Dressing changes necessary at work

☐ No Running

12. OTHER RESTRICTIONS (if any):

16. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)

☐ Advised to take over-the-counter meds

☐ Medication may make patient drowsy

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

17. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on _____ (date) at ____ : _____ am/pm

☐ Referral to/Consult with _____ on _____ (date) at ____ : _____ am/pm

☐ Physical medicine ___ X per week for ___ weeks starting on _____ (date) at ____ : _____ am/pm

☐ Special studies (list): _____ on _____ (date) at ____ : _____ am/pm

☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE
Discharge Time		

Employee:
SUBMIT FORM TO
Your Department's Leave Administrator

NEED HELP?
Texas A&M Human Resources Benefit Services
Phone (979) 862-1718 | hrcompbenefits@tamu.edu