Division of Human Resources
& Organizational Effectiveness

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 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

Employee's Name	Date
IN	Date of Injury or Illness
Doctor's Name	Clinic/Facility Name
Clinic's Facility Address – (no P.O. Box)	
Clinic's Phone Number	Fax Number

Part II: Work Status Information (Fully complete one including estimated dates and description in part III as applicable

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:

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Part III: Activity Restrictions* (required if Part II (b) is checked)

Posture Restrictions (if any):
Max Hours per day

	0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	_____
Sitting	☐	☐	☐	☐	☐	_____
Kneeling/Squatting	☐	☐	☐	☐	☐	_____
Bending/Stooping	☐	☐	☐	☐	☐	_____
Pushing/Pulling	☐	☐	☐	☐	☐	_____
Twisting	☐	☐	☐	☐	☐	_____
Other	☐	☐	☐	☐	☐	

Motion Restrictions (if any):
Max Hours per day

	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	_____
Climbing Stairs/Ladders	☐	☐	☐	☐	☐	_____
Grasping/Squeezing	☐	☐	☐	☐	☐	_____
Wrist fexion/extension	☐	☐	☐	☐	☐	_____
Reaching	☐	☐	☐	☐	☐	_____
Overhead Reaching	☐	☐	☐	☐	☐	_____
Keyboarding	☐	☐	☐	☐	☐	_____
Other	☐	☐	☐	☐	☐	

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

Restrictions Specific to (if applicable):

- ☐ L Hand/Wrist ☐ R Hand/Wrist
- ☐ L Arm ☐ R Arm ☐ Neck ☐ Back
- ☐ L Foot/Ankle ☐ R Foot/Ankle
- ☐ Other_____

Lift/Carry Restrictions (if any):

- ☐ May not lift/carry objects more than _____lbs.
- For more than _____hours per day
- ☐ May not perform any lifting/carrying
- ☐ Other:_____

Medication Restrictions (if any):

- ☐ Must take prescription medications(s)
- ☐ Advised to take over-the-counter meds
- ☐ Medication may make patient drowsy

Part IV" Treatment/Follow-up appointment information

Expected follow-up Services included:

- ☐ Evaluation by the treating doctor on _____ (date) at _____ " _____ a.m./p.m.
- ☐ Referral to/Consult with _____ on _____ (date) at _____ : _____ a.m./p.m.
- ☐ Physical medicine _____x per week for _____weeks starting on _____ (date) at _____ : _____ a.m./p.m.
- ☐ Special studies (list: _____ on (date) at _____ : _____ a.m./p.m.
- ☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Distribution:
Your Department's Liaison
1. Original – Employee's medical file
2. Copy – Employee

NEED HELP?
Employee Relations Department (ER
979.862.4027
Employee-Relations@tamu.edu

Office Use Only

Date received form	Received by