



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)

<p>10. POSTURE RESTRICTIONS (if any):</p> <p>Max Hours per day: 0 2 4 6 8 Other</p> <p>Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Kneeling/Squatting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Bending/Stooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Pushing/Pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Twisting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p>	<p>13. MOTION RESTRICTIONS (if any):</p> <p>Max Hours per day: 0 2 4 6 8 Other</p> <p>Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Climbing stairs/ladders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Grasping/Squeezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Wrist flexion/extension <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Overhead Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Keyboarding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p>	<p>15. MISC. RESTRICTIONS (if any):</p> <p><input type="checkbox"/> Max hours per day of work: _____</p> <p><input type="checkbox"/> Sit/Stretch breaks of _____ per _____</p> <p><input type="checkbox"/> Must wear splint/cast at work</p> <p><input type="checkbox"/> Must use crutches at all times</p> <p><input type="checkbox"/> No driving/operating heavy equipment</p> <p><input type="checkbox"/> Can only drive automatic transmission</p> <p><input type="checkbox"/> No work / <input type="checkbox"/> _____ hours/day work:</p> <p><input type="checkbox"/> in extreme hot/cold environments</p> <p><input type="checkbox"/> at heights or on scaffolding</p>
<p>11. RESTRICTIONS SPECIFIC TO (if applicable):</p> <p><input type="checkbox"/> L Hand/Wrist <input type="checkbox"/> R Hand/Wrist</p> <p><input type="checkbox"/> L Arm <input type="checkbox"/> R Arm <input type="checkbox"/> Neck</p> <p><input type="checkbox"/> L Leg <input type="checkbox"/> R Leg <input type="checkbox"/> Back</p> <p><input type="checkbox"/> L Foot/Ankle <input type="checkbox"/> R Foot/Ankle</p> <p><input type="checkbox"/> Other: _____</p>	<p>14. LIFT/CARRY RESTRICTIONS (if any):</p> <p><input type="checkbox"/> May not lift/carry objects more than _____ lbs. for lbs..</p> <p>for more than _____ hours per day</p> <p><input type="checkbox"/> May not perform any lifting/carrying</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> Must keep _____:</p> <p><input type="checkbox"/> Elevated <input type="checkbox"/> Clean & Dry</p> <p><input type="checkbox"/> No skin contact with: _____</p> <p><input type="checkbox"/> Dressing changes necessary at work</p> <p><input type="checkbox"/> No Running</p>
<p>12. OTHER RESTRICTIONS (if any):</p>		<p>16. MEDICATION RESTRICTIONS (if any):</p> <p><input type="checkbox"/> Must take prescription medication(s)</p> <p><input type="checkbox"/> Advised to take over-the-counter meds</p> <p><input type="checkbox"/> Medication may make patient drowsy</p>

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		

<p>Employee: SUBMIT FORM TO Your Department's Leave Administrator</p>	<p>NEED HELP? Texas A&M Human Resources Benefit Services Phone (979) 862-1718 hrcombenefits@tamu.edu</p>
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