

WORK STATUS REPORT

Employee: _____

Employer: _____

Diagnosis: _____

Full Duty: _____

Light Duty: _____

No work until: _____

Date of re-check: _____

Remarks: _____

Date at MMI: _____

PPD Rating (AMA Guidelines): _____% to the _____

(body part)

_____ % to the body as a whole

WORK LIMITATIONS

Unable to work - NO WORK

Sit down work _____ % of the time.

Standing work _____ % of the time.

Must have _____ minute break every _____ hour(s)

No lifting over _____ lbs.

No work performed on uneven or inclined surfaces.

No work where the use of _____ is required.

No climbing, squatting, crawling.

No driving.

Medically necessary to work in: Cast Brace _____

Medication prohibits _____

Other: _____

Physician Signature

Date