Print Form

COUNTY OF ALAMEDA WORK STATUS REPORT

To the Attending Physician*:

Please fill out this form completely at time of treatment & provide copy to employee for supervisor.

Name of Employee: _____ Dept. Name or Number: _____ ☐ INDUSTRIAL

Job Title: _____ DOI/Claim #: _____ ☐ NON-INDUSTRIAL

1. I attended the employee for the present medical problem from _____ to _____

2. Is this employee able to work?

CHECK ALL THAT APPLY

☐ Unable to work full duty from _____ to _____
(If checked, you MUST complete items #4 & #5)

☐ Released to modified duty effective _____ to _____
(If checked, you MUST complete items #4 & #5)

☐ Released to full duty effective _____

3. Diagnosis or general nature of illness/injury (*with patient permission*): _____

4. **Indicate medical restrictions below:**

Vehicle Use	*Indicate restrictions & frequency:*
Cars	
Pickup Trucks/Vans/Buses	
Other:	
Body Positions	
Standing	
Running	
Walking	
Working on Irregular Surfaces	
Sitting	
Other:	
Bodily Movements	
Bending	
Squatting	
Twisting	
Crawling	
Reaching Overhead	
Other:	

LIFTING/CARRYING

Write in Weight Restriction _____ LBS.

Climbing	*Indicate restrictions & frequency:*
Stairs	
Ladders	
Work on Elevated Surfaces	
Rough Terrain	
Other:	
Repetitive Hand Motion	
Simple Grasping *(pen, screwdriver, etc.)*	
Fine Manipulation *(writing, wiring, etc.)*	
Pushing/Pulling	
Keyboard/Mouse Use	
Twisting *(lock/unlock)*	
Other:	
Environmental	
Temperature/Humidity Extremes	
Fumes/Dust/Gas	
Chemical/Biological Agents	
Exposed to Water/Detergents	
Other:	
Special Tasks	
Ability to Restrain	
Handle Firearms	
Other:	

5. **Estimated return to full duty date:** _____

Must be completed if you are returning employee to ***temporary modified duty.***

Are restrictions above permanent? ◯ No ◯ Yes

Is patient involved in treatment requiring time off and/or taking medication that might affect his/her work?

◯ No ◯ Yes *Please describe:* _____

_____

TIME IN: _____ **TIME OUT:** _____

DATE OF APPOINTMENT: _____

Next appointment: _____
Date *Time*

NOTE: Non-physicians required to complete lower section only

_____
Signature of Treating Physician or Clinician/Therapist

_____
Print or Type Name

_____
Specialty *Date*

_____
Address/City/State/ZIP

_____
Phone *Fax*