

DUTY STATUS REPORT

Patient Name: _____

Date: _____

Job: _____

(To be completed by Physician)

1. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK?

yes no

(If yes, indicate whether part time or full time and the date to resume such work)

part time full time Date: (Month, day, year) _____

2. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK?

yes no

(If yes, check the work tolerance limitations which are due to the injury. Include pre-existing conditions.)

Physical Limitations	Full Restriction	Partial Restriction	No Restriction
Sedentary - lifting 1 to 10 lbs			
Light - lifting 10 to 20 lbs			
Moderate - lifting 20 to 50 lbs			
Heavy - lifting 50 to 100 lbs			
Pulling/pushing, carrying			
Reaching or working above shoulder			
Walking			
Standing			
Sitting			
Stooping			
Kneeling			
Repeated bending			
Climbing			
Operating a Motor Vehicle, Crane, Tractor, etc.			
Exposure limitations (Specify)			

Heat _____ Stress _____

Cold _____ Dust _____ Fumes _____

see other side ⇨

3. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS.

4. PERIOD OF DISABILITY (If termination date unknown, so-indicate)

Total disability from _____ to _____

Partial disability from _____ to _____

Date employee is able to resume work (Mo/Day/Yr) _____

Light work

Regular work

5. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED?

yes no

(If yes, furnish date advised (Mo/Day/Yr) _____

6. DIAGNOSIS OF CONDITION DUE TO INJURY.

7. DATE OF EXAMINATION _____

DATE OF FURTHER APPOINTMENTS, IF ANY _____

8. SIGNATURE AND TYPED/PRINTED NAME OF PHYSICIAN

Signature _____ Date _____

Type/Print Name _____