PHYSICIAN'S REPORT / EMPLOYEE WORK STATUS

***** *Please ensure that the employee receives a copy of this form or that it is faxed to employer.*

EMPLOYEE NAME: _____

EMPLOYER NAME: HR Dept. Mental Health Association, Inc. FAX: 413 737-0769

DX: _____ WORK RELATED: _____ NOT WORK RELATED: _____ UNDETERMINED: _____

RX: _____

THIS PATIENT'S EMPLOYER HAS A "RETURN-TO-WORK PROGRAM' AND IS COMMITTED TO TRYING TO PROVIDE WORK WITHIN ANY RESTRICTIONS

TREATMENT PLAN:

_____ RETURN TO WORK **REGULAR** DUTY DATE OF RETURN: _____

_____ RETURN TO **RESTRICTED** WORK DATES (FROM) _____ (TO) _____

EMPLOYEE CAN:	**NEVER**	**OCCAS**	**FREQ**	**CONT**
Lift/Carry: 0 to 10 lbs				
11 to 25 lbs				
26 to 35 lbs				
36 to 50 lbs				
51 to 75 lbs				
76 to 100 lbs				
Reach above shoulders				
Push / Pull				
Squat / Kneel / Stoop				
Can use hand for:				
Simple grasping				
Firm grasping				
Fine manipulation				
Torqueing				
Driving				

KEY:

Occasionally Up to 33%

Frequently 34 to 66 %

Continuously 67 to 100%

Work hours: _____ Full Shift _____ Partial Shift or _____ Hrs/Day **(Restricted)**

(No. of Hours/Day) _____ Sitting _____ Standing _____ Walking

MODIFICATIONS TO APPLY TO: _____ Work _____ Home _____ Leisure

Unable to work from: _____/_____/_____ (Date) to _____/_____/_____ (Date)

Additional Comments: _____

Return to Clinic on: _____/_____/_____ (Date) to _____/_____/_____ (Date)

Physical Therapy at: _____ Frequency: _____ Duration: _____

Physician's Name (printed): _____ Clinic: _____

Physician's Signature: _____ Address: _____

Date: City: _____

Phone: _____ Fax: _____

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