WORK STATUS REPORT

Date _____

☐ **SICK LEAVE VERIFICATION**

☐ **WORKERS' COMPENSATION**

Patient Name _____ Time In _____

is able to return to work on _____ Time Out _____

DIAGNOSIS _____

_____

_____

☐ is working and NOT DISABLED from work.

☐ is DISABLED from _____ to _____.

☐ is released to return to MODIFIED work on _____ WITH RESTRICTIONS of:

- ☐ No lifting over ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. ☐ _____ lbs.
- ☐ No soiling or wetting of dressing and/or wound.

☐ Limited use of: ☐ Right ☐ Left ☐ Arm ☐ Leg ☐ Shoulder ☐ Hand

☐ Limited: ☐ Standing ☐ Walking ☐ Sitting ☐ Stooping ☐ Bending

☐ Anticipated duration of the MODIFIED status above is _____ days.

☐ Patient is still to remain on MODIFIED duty — same restriction.

☐ PHYSICAL THERAPY has been scheduled _____ times a week for _____ weeks.

☐ IS released for REGULAR WORK beginning _____

☐ WILL PROBABLY BE released for REGULAR WORK beginning _____

☐ Next appointment date _____ time _____

☐ Injury requires no further treatment.

☐ Discharged as cured, no permanent disability.

Doctor Signature _____

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