New York University - Work Related Injury / Illness - Physician's Status Report

Completed form required to return to work after a work-related absence of 3 or more days.

PART I: GENERAL INFORMATION

1. Employee's Name	4. Physician's Name
2. Date of Injury or illness	5. Clinic/Facility Name
3. Medical facts of condition	6. Clinic/Facility/Physician's Phone & Fax
	7. Clinic/Facility/–Physician's Address (street address)
	8. City State Zip

PART II: WORK STATUS INFORMATION (FULLY COMPLETE INCLUDING ESTIMATED DATES AND DESCRIPTION IN PART III AS APPLICABLE)

9. The injured employee's medical condition resulting from the injury or illness:

(a) will allow the employee **to return to work** as of __________ (date) **without restrictions**.

(b) will allow the employee **to return to work** as of __________ (date) **with the restrictions identified in PART III**, which are expected to last through __________ (date).

(c) has prevented and still prevents the **employee from returning to work** as of __________ (date) and is expected to continue through __________ (date). The following describes how this injury **prevents the employee from returning to work:**

PART III: ACTIVITY RESTRICTIONS* (REQUIRED IF PART II (b) IS CHECKED)

10. POSTURE RESTRICTIONS (if any):

Max Hours per day: 0 2 4 6 8 Other

- Standing ______
- Sitting ______
- Kneeling/Squatting ______
- Bending/Stooping ______
- Pushing/Pulling ______
- Twisting ______
- Other: _______

11. RESTRICTIONS SPECIFIC TO (if applicable):

L Hand/Wrist	R Hand/Wrist	
L Arm	R Arm	Neck
L Leg	R Leg	Back
L Foot/Ankle	R Foot/Ankle	
Other:		

13. MOTION RESTRICTIONS (if any):

Max Hours per day: 0 2 4 6 8 Other

- Walking ______
- Climbing stairs/ladders ______
- Grasping/Squeezing ______
- Wrist flexion/extension ______
- Reaching ______
- Overhead Reaching ______
- Keyboarding ______
- Other: ______

14. LIFT/CARRY RESTRICTIONS (if any):

May not lift/carry objects more than _____ lbs. - for more than ____ hours per day

May not perform any lifting/carrying

Other:

15. MISC. RESTRICTIONS (if any):

- Max hours per day of work: _______
- Sit/Stretch breaks of ______ per ______
- Must wear splint/cast at work
- Must use crutches at all times
- No driving/operating heavy equipment
- Can only drive automatic transmission
- No work / _____ hours/day work:
  - in extreme hot/cold environments
  - at heights or on scaffolding
- Must keep ______________________:
  - Elevated
  - Clean & Dry
- No skin contact with: _______________
- Dressing changes necessary at work
- No Running

12. OTHER RESTRICTIONS (if any):

* These restrictions are based on the physician's best understanding of the employee's job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

16. MEDICATION RESTRICTIONS (if any):

- Must take prescription medication(s)
- Advised to take over-the-counter meds
- Medication may make drowsy (possible safety/driving issues)

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

17. Expected Follow-up Services Include:

Evaluation by the treating physician on __________ (date) at ____ : ____ am/pm

Referral to/Consult with ________________________ on __________ (date) at ____ : ____ am/pm

Physical medicine ___ X per week for ___ weeks starting on __________ (date) at ____ : ____ am/pm

Special studies (list): ___________________________ on __________ (date) at ____ : ____ am/pm

None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Physician's PRINTED Name: ____

Physician's Signature____ Date of Visit ____________________________