

**Work Status Form for
Injured Employee**

Section A - General Information	
Injured Worker Name:	Claim Number:
Employer Name:	Date of Injury:
Occupation/Title:	Date of Birth:

Section B - Return to Work Status (Please Choose One)

Employee can return to work to perform the essential function of the position per the job description as of _____ (Date) **WITHOUT restrictions.**

Employee can return to work on a temporary transitional duty basis provided the work is consistent with the activity restrictions identified in Section C: _____ (Date) which are expected to last through _____ (Date).

Employee is unable to return to work per the job description _____ (Date) and is expected to last through _____ (Date)

Section C - Employee is released to temporary transitional duty with the following Activity Restrictions (Choose all that apply)

EMPLOYEE IS ABLE TO WORK 4 ____ 6 ____ 8 ____ 12 ____ TOTAL HOURS PER DAY.

Posture Restrictions (if any)		Motion Restrictions (if any)		Driving Restrictions (if any):	Restrictions Specific To (if any):	
<input type="checkbox"/> Standing	Hours	<input type="checkbox"/> Walking	Hours		<input type="checkbox"/> No driving/operating heavy equipment <input type="checkbox"/> Night time restrictions <input type="checkbox"/> Can only drive automatic transmission	<input type="checkbox"/> Left Arm
<input type="checkbox"/> Sitting	Hours	<input type="checkbox"/> Climbing stairs/ladders	Hours	<input type="checkbox"/> Right Arm		<input type="checkbox"/> Right Hand/Wrist
<input type="checkbox"/> Kneeling/Squatting	Hours	<input type="checkbox"/> Grasping/Squeezing	Hours	<input type="checkbox"/> Neck		<input type="checkbox"/> Back
<input type="checkbox"/> Bending/Stooping	Hours	<input type="checkbox"/> Wrist flexion/extension	Hours	<input type="checkbox"/> Left Leg		<input type="checkbox"/> Left Foot/Ankle
<input type="checkbox"/> Pushing/Pulling	Hours	<input type="checkbox"/> Reaching	Hours	<input type="checkbox"/> Right Leg		<input type="checkbox"/> Right Foot/Ankle
<input type="checkbox"/> Twisting	Hours	<input type="checkbox"/> Overhead Reaching	Hours	Medication Restrictions (if any):		
<input type="checkbox"/> Other	Hours	<input type="checkbox"/> Keyboarding	Hours	<input type="checkbox"/> Medication may make drowsy (possible safety/driving issues)		
Misc. Restrictions (if any)				Lift/Carry Restrictions (if any):		
<input type="checkbox"/> Must use crutches at all times		<input type="checkbox"/> Must wear splint/cast at work		<input type="checkbox"/> May not lift/carry objects more than ____ lbs for more than ____ hours per day.		
<input type="checkbox"/> No work/ ____ hours/day work:		<input type="checkbox"/> Sit/Stretch Breaks of ____ per ____		<input type="checkbox"/> May not perform any lifting/carrying		
<input type="checkbox"/> at heights or on scaffolding		<input type="checkbox"/> Must keep _____		Other Restrictions (if any):		
<input type="checkbox"/> in extreme hot/cold environments		<input type="checkbox"/> Clean & Dry <input type="checkbox"/> Elevated				

Activity restrictions are to be complied with while you are at work and also outside of work.

Section D - Employee Treatment/Follow-Up Information (Fill in or Check all that apply)

Diagnosis Code:	Diagnosis Description:	Is the injury work related? (check one) <input type="checkbox"/> Yes <input type="checkbox"/> No
Is there any further treatment needed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what treatment _____ (please list) and for how long _____		
<input type="checkbox"/> The injured employee has reached MMI as of _____ (Date)	<input type="checkbox"/> Diagnostic Study (Please Specify) _____	
<input type="checkbox"/> Follow up visit on _____ (date) at _____ : _____ am/pm	<input type="checkbox"/> Referral to Specialist _____	
<input type="checkbox"/> Receive Physical Therapy ____ X per week for ____ weeks	<input type="checkbox"/> Work Conditioning	<input type="checkbox"/> Work Hardening <input type="checkbox"/> Pain Management ____ X per week for ____ weeks
Physician Name (Please Print):	Date of Visit:	
Physician Signature:	Employee's Signature:	

Fax the completed report to WorkLink immediately after each visit to (713) 338-6590.

PLEASE GIVE A COMPLETED COPY OF THE FORM TO THE INJURED WORKER

*Please fill out all relevant information on the form. Our company takes a proactive approach to returning the injured worker back to work. Utilizing the information on this form, we assign employees to temporary transitional duty work assignments.

*Please do not bill or collect any money from the injured employee.

*Send ALL bills to WorkLink.

*Please call (713) 338-6519 Option 1 for billing and/or pharmacy information.