

**PARTNERS HEALTHCARE SYSTEM
OCCUPATIONAL HEALTH SERVICE
WORK STATUS FORM**

Attn: _____
Telephone: _____
Fax #: _____

Employee Name: _____ Date: _____
Hospital Employee #: _____ Dept: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

The above employee has been evaluated for return to work. He/She is (check the appropriate box):

- Able to return to work without restrictions _____
- Unable to work from _____ to _____
- Able to return to work with the following restrictions from _____ to _____

Please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> May work ___ hrs/day, ___ days/week. | <input type="checkbox"/> Squatting/kneeling limited to ___ hrs/day |
| <input type="checkbox"/> No pushing/pulling greater than ___ lbs. | <input type="checkbox"/> Stair climbing limited to ___ hrs/day |
| <input type="checkbox"/> No lifting/carrying greater than ___ lbs. | <input type="checkbox"/> Sitting limited to ___ hrs/day |
| <input type="checkbox"/> Computer use limited to ___ hrs/day | <input type="checkbox"/> Standing limited to ___ hrs/day |
| <input type="checkbox"/> Repetitive bending/stooping limited to ___ hrs/day | <input type="checkbox"/> Walking limited to ___ hrs/day |
| <input type="checkbox"/> Drive limited to ___ hrs/day | <input type="checkbox"/> Climbing ladders limited to ___ hrs/day |
| <input type="checkbox"/> Repetitive movement of ___ limited to ___ hrs/day | |
| <input type="checkbox"/> Overhead work limited to ___ hrs/day | |
| <input type="checkbox"/> No overtime work | |
| <input type="checkbox"/> Consecutive work shift restriction | |

Other: _____

The next follow up examination is scheduled on _____
Date

Health Care Provider Signature

Date