

NORTH EAST INDEPENDENT SCHOOL DISTRICT WORK STATUS FORM

Dear Medical Provider: It is our understanding that you are currently treating the below-named employee. In order to obtain accurate work status information, please complete the information below and return this form to our office. Thank you for your assistance.

Sincerely,
 Carol Kobernat, Leave Coordinator, Human Resources
 8961 Tesoro Drive, San Antonio, TX 78217

Tel: (210) 407-0497

Fax: (210) 804-7031

PART I: General Information (Items 1 – 8 MUST be completed for processing)		5. Employee's Campus/Department Location		(for transmission purposes only)	Date Being Sent
		1. Employee's Name		6. Doctor's Name and Degree	
2. Employee's Job Title		3. Social Security Number		7. Clinic/Facility /Doctor Phone & Fax	
4. Employee's Medical Condition		8. Clinic/Facility/Doctor Address (street add-s)		9. Employer's Name North East Independent School District	
		City State Zip		10. Employer's Address 8961 Tesoro Dr., San Antonio, TX 78217	
				11. Employer's FAX # (210) 804-7031	
				12. Attention Carol Kobernat, Leave Coordinator	

PART II: Work Status Information (Fully complete one including estimated dates and description in 13(c) as applicable)

13. The employees medical condition:

- (a) will allow the employee to return to work as of _____ (date) **without restrictions** – **ONLY COMPLETE THIS LINE IF THERE ARE NO RESTRICTIONS INDICATED IN PART III.**
- (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 the condition prevents the employee from returning to work:

PART III: Activity Restrictions * (Only complete if 13(b) is checked)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kneeling/Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending/Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

17. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Climbing stairs/ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grasping/Squeezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wrist flexion/extension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overhead Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Keyboarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

19. 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

15. RESTRICTIONS SPECIFIC TO (if applicable):

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

18. 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: _____

16. OTHER RESTRICTIONS (if any):

FOR BUS DRIVERS ONLY: PLEASE INDICATE IF EMPLOYEE CAN DRIVE A SCHOOL BUS.

*These restrictions are based on the doctor's best understanding of the employee's essential 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 work as well as work.

20. 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

21. Comments

22. Expected Follow-up Services Include:

- Evaluation by the treating doctor 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.

Date/Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visitor Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-up
Discharge Time			