NORTH EAST INDEPENDENT SCHOOL DISTRICT WORK STATUS FORM

Dear Medical Provider: It is our understanding that you are currently treating the employee listed below. In order to obtain accurate work information, please complete the information and return this form to our office. Thank you for your assistance, Michele Matheny, Leave Management Specialist in Human Resources, 8961 Tesoro Drive, San Antonio, Texas 78217**, Phone: 210-407-0497** and **Fax: 210-805-2767.**

Part I: General Information (Items 1-7 MUST be completed by the EMPLOYEE for processing.)

1. Employee Name	2. Date of Birth	3. Employee Job Title
4. Employee's Campus/Department Location	5. Doctor's Name and Degree	
6. Clinic/Facility Name: Address: City, State, Zip: Phone & Fax:	7. Date Sent to NEISD	8. Employer's Name: **North East Independent School District** Address: **8961 Tesoro Dr. San Antonio, TX 78217** Fax: (**210)-805-2767** Attention**: Michele Matheny, Leave Management Specialist**

Part II: Work Status Information (Select one option with estimated dates and description of condition 10(c) as applicable)

10. The employee's 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 10(b) is checked)

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: _____

12. POSTURE RESTRICTIONS (if any):
Please list **Max. Hours per day** from a **scale of 0-8 hours.**

_____ Hours Standing

_____ Hours Sitting

_____ Hours Kneeling/Squatting

_____ Hours Bending/Stooping

_____ Hours Pushing/Pulling

_____ Hours Twisting

_____ Hours Other_____

_____

13. MOTION RESTRICTIONS (if any):
Please list **Max. Hours per day** from a **scale of 0-8 hours.**

_____ Hours Walking

_____ Hours Climbing Stairs/Ladders

_____ Hours Grasping/Squeezing

_____ Hours Wrist Flexion/Extension

_____ Hours Reaching

_____ Hours Overhead Reaching

_____ Hours Keyboarding

_____Hours 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. MISCELLANEOUS 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

16. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ Medications may cause drowsiness (possible Safety/Driving issues)

17. OTHER RESTRICTIONS (if any):
IF PATIENT IS A BUS DRIVER, 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 of work as well.)

Part IV: Treatment/Follow-up Appointment Information

18. Comments:

_____
_____
_____
_____
_____
_____

19. 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 time 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 employee. At this time, no further medical care is anticipated.

20. Visit Type: ☐ Initial ☐ Follow-Up

21. Date/Time of Visit:_____

Discharge Time: _____

Employee's Signature:	**Doctor's Signature**	**Date**