SAN ANTONIO INDEPENDENT SCHOOL DISTRICT

WORK STATUS FORM

Employee's Name	Physician	Primary (Dx) ICD-10	☐ Initial Visit ☐ Follow Up
Date of Injury/Illness	Physician Telephone No.	Employer's Name: **San Antonio ISD**	
Last 4 - Social Security No. xxx-xx-_____	Physician Address	Employer's Fax# or E-mail address: **(210) 228-3145**	
Date of This Visit	Type of Injury/Illness		

Dear Medical Provider:
It is our understanding that you are currently treating the above-named employee. San Antonio ISD has a Transitional Duty Program in which employees with physical restrictions are allowed to return to work to perform job duties within their physical capabilities. Please complete the information below and return this form to our office. If you have any questions regarding our Transitional Duty Program, please contact Employee Benefits, Risk Management and Safety (EBRMS) at (210) 554-8667 or (210) 554-8660.

WORK STATUS INFORMATION (*Select one option*)

Check the employee's medical condition:

☐ has been resolved and the employee may **return to work without restrictions** as of _____ (date).

☐ has improved enough to allow the employee **to return to work with restrictions** as of _____(date). The restrictions on the employee's work activities are noted below on this report and are expected to last until at least _____ (date).

☐ is such that the employee is **unable to work** and restricted from all work as of _____ (date). This restriction is expected to last until _____(date) at which time the employee is expected to be able to return to work with or without restrictions.

WORK RESTRICTIONS

Activity Restrictions

Posture Restrictions (if any):

Max hours per day:	**0**	**2**	**4**	**6**	**8**	**Other:**
Standing	☐	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	☐	
Kneeling/squatting	☐	☐	☐	☐	☐	
Bending/stooping	☐	☐	☐	☐	☐	
Pushing/pulling	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Other:						

Restrictions Specific To (if applicable):

☐ Left hand/wrist	☐ Left leg
☐ Right hand/wrist	☐ Right leg
☐ Left arm	☐ Back
☐ Right arm	☐ Left foot/ankle
☐ Neck	☐ Right foot/ankle
Other:	

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:						

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:

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 skin contact with: _____
☐ No running
☐ Dressing changed necessary at work
☐ No work/_____ hours/day work:
  ☐ in extreme hot/cold enviroments
  ☐ at heights or on scaffolding
☐ Must keep _____
  ☐ elevated
  ☐ clean & dry

Medication Restrictions (if any:)

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

Other Restrictions (if any):

FOLLOW-UP APPOINTMENT INFORMATION

Expected Follow-up Service Include: _____(Date) _____(Time)

Physician Signature:		**Date:**	