



Physician's Report/Employee Work Status/Return To Work

PHYSICIAN: Please ensure that the employee receives a copy of this form and/or that it is faxed to the City of Duluth (218) 730-5906. If work related, please also fax to SFM (952) 838-2000.

Please respond with information specific to the current condition and job description requirements only.

| | | | |
|---|--|--|-------------|
| Name (Last, First, Middle) | | Social Security Number | |
| Address | | | |
| <input type="checkbox"/> Work-Related <input type="checkbox"/> Not Work-Related <input type="checkbox"/> Undetermined | | | |
| Dx: | | Date of Onset of Injury/Illness: | |
| Physical Therapy at: | | Frequency: | Duration: |
| <input type="checkbox"/> Return to Work, Regular Duty: ___/___/___ (Date) | | MMI: <input type="checkbox"/> Yes <input type="checkbox"/> No ___/___/___ (Date) | PPD: _____% |
| <input type="checkbox"/> Return to Work, Restricted Duty: ___/___/___ (Date) | | To: ___/___/___ (Date) | |

Please respond with information specific to the current condition and job description requirements only.

| EMPLOYEE CAN: | NEVER | OCCASIONALLY | FREQUENTLY | CONTINUOUSLY |
|----------------------------|-------------------------------------|--|---|--------------------------|
| Lift/Carry: | | | | |
| 0 to 10 lbs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 to 25 lbs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26 to 35 lbs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 36 to 50 lbs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 51 to 75 lbs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 76 to 100 lbs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reach above shoulder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Push/Pull | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Squat/Kneel/Stoop..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bend..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can use L/R Hand for: | | | | |
| Simple Grasping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Firm Grasping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fine Manipulation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Torquing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Work Hours: | <input type="checkbox"/> Full Shift | <input type="checkbox"/> Partial Shift | <input type="checkbox"/> Restricted Hours Per Day | |
| Number of Hours/Day: | Sitting: _____ | Standing: _____ | Walking: _____ | |
| Modifications Apply to: | <input type="checkbox"/> Work | <input type="checkbox"/> Home | <input type="checkbox"/> Leisure | |

| | | |
|---|------------------------|---|
| This patient's employer has a return-to-work program and is committed to providing work within any restrictions. | | |
| Unable to Work from: ___/___/___ (Date) | To: ___/___/___ (Date) | Return to Clinic on: ___/___/___ (Date) |
| Additional Comments: | | |
| | | |
| Referral to: | | |
| Physician's Signature | | Date |
| Printed Name | | Phone |
| Clinic | | Address |
| Fax | | |