COUNTY OF ALAMEDA WORK STATUS REPORT

To the Attending Physician/Clinician*:

Please fill out this form completely at time of treatment & provide copy to employee for supervisor.

NAME OF EMPLOYEE: _____ **DEPT. NAME OR NUMBER**: _____ ☐ INDUSTRIAL

JOB TITLE: _____ **DOI/CLAIM #**: _____ **EMPLOYEE ID #:**_____ ☐ NON-INDUSTRIAL

1. I attended the employee for the present medical problem from _____ to _____

2. Is this employee able to work? ☐ **Unable to work full duty from _____ to _____**
(If checked, you MUST complete items #4 & #5)

CHECK ALL THAT APPLY ☐ **Released to modified duty effective _____ to _____**
(If checked, you MUST complete items #4 & #5)

☐ **Released to full duty effective _____**

3. Diagnosis or general nature of illness/injury (*with patient permission*): _____

4. Indicate specific medical restrictions below:

Vehicle Use	***Indicate restrictions & frequency:***
Cars	
Pickup Trucks/Vans/Buses	
Other:	
Body Positions	
Standing	
Running	
Walking	
Working on Irregular Surfaces	
Sitting	
Other:	
Bodily Movements	
Bending	
Squatting	
Twisting	
Crawling	
Reaching Overhead	
Other:	
Lifting/Carrying	
Write in Weight/Carry Restriction _____ LBS	

Climbing	***Indicate restrictions & frequency:***
Stairs	
Ladders	
Work on Elevated Surfaces	
Rough Terrain	
Other:	
Repetitive Hand Motion	
Simple Grasping *(pen, screwdriver, etc.)*	
Fine Manipulation *(writing, wiring, etc.)*	
Pushing/Pulling	
Keyboard/Mouse Use	
Twisting *(lock/unlock)*	
Other:	
Environmental	
Temperature/Humidity Extremes	
Fumes/Dust/Gas	
Chemical/Biological Agents	
Exposed to Water/Detergents	
Other:	
Special Tasks	
Ability to Restrain/Arrest/Subdue	
Handle Firearms	
Other:	

5. Estimated return to full duty date: _____
Note: Must be completed if you are returning employee to ***temporary modified work.***

6. Are restrictions above permanent? ☐ **No** ☐ **Yes**

7. Is patient involved in treatment requiring time off and/or taking medication that might affect his/her work? ☐ **No** ☐ **Yes** *Please describe:*
_____

NOTE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

TIME IN: _____ **TIME OUT:** _____

DATE OF APPOINTMENT: _____

Next appointment: _____
Date *Time*

****NOTE: Non-physicians required to complete lower section only***

_____
Signature of Treating Physician or Clinician/Therapist

_____
Print or Type Name

_____
Name of Medical Group/Clinic ***Date***

_____
Address/City/State/ZIP

_____
Phone ***Fax***