CARRIZO SPRINGS C.I.S.D 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,
Human Resources Director
300 N. Seventh St., Carrizo Springs, TX 78834 Tel: (830) 876-3503 **Fax: (830) 876-3619**

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	9. Employer's Name: Carrizo Springs CISD	
2. Employee's Job Title / 3. Social Security Number	7. Clinic/Facility /Doctor Phone & Fax	10. Employer's Address: 300 N. Seventh St., Carrizo Springs, TX 78834	
4. Employee's Medical Condition	8. Clinic/Facility/Doctor Address:	11. Employer's FAX #: **(830) 876-3619**	
	City State Zip	12. Attention: Human Resources Director	

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	☐	☐	☐	☐	☐	_____
Sitting	☐	☐	☐	☐	☐	_____
Kneeling/Squatting	☐	☐	☐	☐	☐	_____
Bending/Stooping	☐	☐	☐	☐	☐	_____
Pushing/Pulling	☐	☐	☐	☐	☐	_____
Twisting	☐	☐	☐	☐	☐	_____
Other _____	☐	☐	☐	☐	☐	_____

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: _____

17. 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: _____	☐	☐	☐	☐	☐	_____

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

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

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 of Visit	EMPLOYEE'S SIGNATURE:	DOCTOR'S SIGNATURE:	Visitor Type: ☐ Initial ☐ Follow-up	