**Oregon State University - Employee Status Report (Workers’ Compensation)**

**Employee Name:**  **Date of Next Appointment:**

**NOTE:** This form is used to assist the University in providing employees with reasonable accommodations and/or transitional work. **PLEASE DO NOT INCLUDE MEDICAL DIAGNOSIS.**

**Current Status (check one only):**

[ ] Released to regular work without restrictions Date:

[ ]  Released to modified work (indicate restrictions below) Date:

[ ]  Not released to any form of work\* Date:

 \* Estimated date of release to work:

Restrictions (fill in the blank, check box or circle restriction for each activity):

In a work day, limitations include: **SIT** hours; **STAND** hours; **WALK** hours

At one time, limitations include: **SIT** hours; **STAND** hours; **WALK** hours

0% 1-5% 6-33% 34-66% 67-100%
 Never Intermittently Occasionally Frequently Continuously

**BEND/ STOOP** [ ]  [ ]  [ ]  [ ]  [ ]

**CLIMB** [ ]  [ ]  [ ]  [ ]  [ ]

**CRAWL** [ ]  [ ]  [ ]  [ ]  [ ]

**PUSH** [ ]  [ ]  [ ]  [ ]  [ ]

**PULL** [ ]  [ ]  [ ]  [ ]  [ ]

**REACH (above shoulder)** [ ]  [ ]  [ ]  [ ]  [ ]

**SQUAT** [ ]  [ ]  [ ]  [ ]  [ ]

**LIFT/CARRY/PUSH/PULL (weight restrictions)**

 Up to 10 lbs.[ ]  [ ]  [ ]  [ ]  [ ]

 11-20 lbs. [ ]  [ ]  [ ]  [ ]  [ ]

 21-30 lbs.[ ]  [ ]  [ ]  [ ]  [ ]

 31-40 lbs.[ ]  [ ]  [ ]  [ ]  [ ]

 41-50 lbs.[ ]  [ ]  [ ]  [ ]  [ ]

 51-100 lbs.[ ]  [ ]  [ ]  [ ]  [ ]

**Use of Hands: Repetitive Action Simple Grasping Pushing/Pulling Fine Manipulation**

Right N I O F C N I O F C N I O F C N I O F C

Left N I O F C N I O F C N I O F C N I O F C

N = Never 0% I = Intermittently 1-5% O = Occasionally 6-33% F = Frequently 34-66% C = Continuously 67-100%

Is the commute (as driver or passenger) to work within physical capacities of the employee? [ ]  Yes [ ]  No

Estimated time for transitional duty: Medically stationary? [ ]  Yes (date) [ ]  No

Please list any restrictions you believe will be permanent and affect the ability of the employee to perform work:

Please list side effects from medication (prescribed for use during work hours) that may impair employee’s ability to safely perform work tasks:

Comments:

Print Physician’s Name: Telephone:

Physician’s Signature: Date: