Work Status Report

Patient: _____ Employer: _____

SSN: _____ Date of Birth: _____ Date of Injury: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the Liberty Mutual Insurance and all physicians or medical providers to release and disclose to MMSC and/or my employer all requested information, records, and copies (including, but not limited to, a completed Work Status Report) regarding my condition, diagnosis, treatment, prognosis, and evaluation for the above specified accident/injury/illness, and any impairment or disability resulting therefrom. I further authorize the disclosure of such information and medical/surgical records to, and discussion of my condition, diagnosis, treatment, prognosis, evaluation, and any resulting impairment or disability with Liberty Mutual Insurance or my employer. Such information, records, and copies may be disclosed and released by mail, personal delivery, facsimile transmission, verbally, or by such other means as requested. Photocopies of this authorization shall be effective as the original.

Employee Signature: _____ Date: _____

Diagnosis or Condition:

WORK STATUS AND FOLLOW-UP TREATMENT

☐ Return To Regular/Full Duty Work Date: _____
(No Limitations or Restrictions)

☐ Reached Maximum Medical Improvement:
Date: _____

☐ Follow-up Or Referral Appointment:
with _____ Date: _____

☐ Return To Work In Restricted/Modified Duty (See Below)
Assignment With The Following Restrictions:

☐ Other:

Recommended Treatment Plan:

RESTRICTIONS (Please Check/Complete All Appropriate Boxes)

☐ **LIFTING ABILITIES:** may lift up to: 0 10 20 25 30 35 40 50 or ____ pounds _____ times/hr _____ hours/shift

☐ **SITTING ABILITIES:** may sit: 0 20 30 40 50 or ____ minutes/hour _____ hours/shift

☐ **STANDING/WALKING ABILITIES:** _____ hours/shift _____ minutes/hour

☐ **CARRYING ABILITIES:** _____ pounds _____ times/hour

☐ **BENDING/TWISTING/STOOPING ABILITIES:** _____ hours/shift

☐ **PUSHING/PULLING ABILITIES:** _____ pounds

☐ **ENDURANCE ABILITIES:** _____ hours/shift _____ days/week

☐ **REPETITIVE ABILITIES:** No repetitive movement of _____

☐ **PROTECTION:** Change in Personal Protection Equipment: _____

☐ **NO REACHING ABOVE SHOULDER HEIGHT**

☐ **NO REACHING BELOW WAIST**

☐ **NO REACHING BELOW KNEES**

☐ **DRY WORK ONLY**

☐ **NO EXPOSURE TO DUST/FUMES**

☐ **OTHER:**

Physician's Signature: _____ Date: _____

Physician's Address _____ Telephone: _____

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