employer solutions staffing group
Leveraging Resources in a Changing Market

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WORK STATUS REPORT/MEDICAL SERVICE FORM

EMPLOYEE INFORMATION:

Name: _____ Date of Birth: _____
Social Security Number: _____ Phone#: (___) _____-_____
Date Of Injury: _____ Time of Injury: _____ ☐ a.m. ☐ p.m.
Job Description: _____

Drug/Alcohol Test: Yes or No **(FOR ALL WORK RELATED INJURIES)**

EMPLOYER INFORMATION:

Company: Employer Solutions Staffing Group, LLC
Phone #: 952-767-0053 Fax #: 952-767-0740 Date Notified: _____
Authorized Employer Signature: _____

EMPLOYER HAS LIGHT DUTY WORK AVAILABLE

TO BE COMPLETED BY PROVIDER:

Diagnosis: _____

Date of Examination: _____/_____/_____ Time: _____ ☐ a.m. ☐ p.m.

Treatment Plan:
_____ Must Return for re-evaluation on: _____/_____/_____
_____ To received PT/OT Services Duration: _____ x week _____x weeks
Surgery Scheduled: _____/_____/_____
_____ Time:_____ ☐ a.m. ☐ p.m. ☐ Inpatient ☐ Outpatient
_____ No further care required Discharge Date: _____/_____/_____

Expected Healing Time:
_____ Days _____ Weeks _____ Months _____
_____ Other _____

Current Status:
_____ May work full duty now (no restrictions) _____/_____/_____ (Date)
_____ May work light duty now with identified restrictions through _____/_____/_____
_____ Presently working as of: _____/_____/_____
_____ Many not work until: _____/_____/_____ ☐ Full Duty ☐ Light Duty
_____ Lifting: Maximum Wight in Lbs.
_____ Pushing: ☐ 0 ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60
_____ Pulling:
Bending: Maximum Times/Hour: ☐ 0-2 ☐ 2-6 ☐ 6-10 ☐ 10-20
_____ Degree of bend: ☐ 10-20 ☐ 20-45 ☐ Full
_____ No Sitting _____ No Standing _____No Walking
_____ Sitting Job Only _____ No Climbing or Overhead Work
_____ May not use: ☐ Right Hand ☐ Left Hand
_____ Keep dressing/wound clean & dry
Medication may cause drowsiness.
_____ Use caution operating machinery or equipment.

Comments: _____

Next Follow Up Appointment:

PHYSICIAN INFORMATION:

Physician Name: _____ Phone: (_____) _____-_____
Physician Signature: _____ Date: _____/_____/_____

Employee: To expedite prompt claim handling, this complete form is to be returned to your employer either on the same day of the appointment or, should lost time be incurred, it is to be forwarded to your employer the day following the appointment.