



JPA School Districts Work Status Report

| | | | |
|-----------------------------|---------------------------------------|---|---------------------------------------|
| Employee's Name | SSN | School District | Date of Injury |
| Date of Visit: _____ | <input type="checkbox"/> First Report | <input type="checkbox"/> Interim Report | <input type="checkbox"/> Final Report |
| CURRENT WORK STATUS: | <input type="checkbox"/> Full Duty | <input type="checkbox"/> Modified Duty | <input type="checkbox"/> Off Work |

PHYSICIAN'S FINDINGS

Diagnosis (with patient's permission): _____

RETURN TO REGULAR WORK: May return to full duty on ___ / ___ / ___

MODIFIED DUTY:

Employee's restrictions are: Temporary Permanent

May return to modified duty on ___ / ___ / ___ *with the following restrictions (check as applicable):*

- | | |
|--|--|
| <input type="checkbox"/> No Lifting over __ 10 __ 20 __ 35 __ 50 lbs. | <input type="checkbox"/> Released to Work with Medication |
| <input type="checkbox"/> No Repetitive (circle as appropriate) Bending/Pushing/Pulling | <input type="checkbox"/> No Operating a Motor Vehicle |
| <input type="checkbox"/> No Repetitive Motion to Injured Part: Body Part _____ | <input type="checkbox"/> Other: __ Eye Patch __ Keep Injury Clean __ Must Wear Splint/Sling |
| <input type="checkbox"/> No Reaching/Working above Shoulder | |
| <input type="checkbox"/> No Climbing: __ Ladders __ Stairs __ Steep Terrain | |

Comments: _____

OFF WORK:

Employee is Temporary Totally Disabled from ___ / ___ / ___ **to** ___ / ___ / ___

(These dates should not start before this treatment date or extend past next appointment date.)

Condition: Same Improved Worsened Request Referral to _____

Discharged, Permanent & Stationary For: PT ___/wk x ___ wks CT/MRI

Ortho Consult Neuro Consult

Permanent Disability: Yes No EMG/NCV Study

REHABILITATION P.T./O.T.

NOTE FOR PT APPOINTMENTS: *Therapist may complete and sign only the portions below.*

Job Description Provided? Yes No Employee is: Improving Maintaining Regressing

TIME IN: _____ **TIME OUT:** _____ **NEXT APPOINTMENT:** Date _____ Time _____

Physician or Clinician Signature _____ Date _____

Physician or Clinician Print Name _____ Phone _____

Address _____ City _____ State/ZIP _____

Tuolumne JPA member school districts offer a Structured Return-to-Work Program to their injured/disabled employees during their medical recovery. We have identified numerous tasks (Temporary Work Assignments) which are available and are designed to accommodate **most** injuries. We can provide a detailed analysis of the temporary work offered to this employee based on your work restrictions. If you have questions or concerns, please contact our Return To Work Coordinator at (209) 536-2035. Thank you for your cooperation.