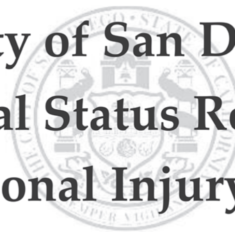
{Affix Label Here}

INSTRUCTIONS: *Employee must submit this form to Physician for completion at **each** Medical Evaluation.*



City of San Diego Medical Status Report for Occupational Injury or Illness

EMPLOYEE

PRINT NAME (LAST, FIRST, MI)	JOB CLASSIFICATION	SOCIAL SECURITY # (LAST 4)	PERN #

DEPARTMENT / DIVISION	DATE OF INJURY	REOCCURRENCE OF OLD DISABILITY? ☐YES ☐NO	IMMEDIATE SUPERVISOR

BRIEF DESCRIPTION OF OCCUPATIONAL INJURY OR ILLNESS / EXPOSURE:

THE FOLLOWING IS AN UPDATE OF MY MEDICAL STATUS IN REGARD TO INDUSTRIAL LEAVE*, AND/OR LIGHT DUTY. TO PRESERVE MY BENEFITS UNDER THE APPROPRIATE PROGRAM, I WILL SUBMIT A MEDICAL STATUS REPORT **EACH TIME** I RECEIVE AUTHORIZED MEDICAL TREATMENT.

I HEREBY AUTHORIZE RELEASE OF MEDICAL INFORMATION REQUESTED BY MY EMPLOYER.

X ______________________ ______________ ______________

Employee Signature   Date   Phone Number

**INDUSTRIAL LEAVE IS SUBJECT TO APPROVAL BY RISK MANAGEMENT IN ACCORDANCE WITH A.R. 63.00.*

PHYSICIAN

TREATING PHYSICIAN (PRINT NAME)	ADDRESS	PHONE

MARK ALL PRESCRIBED	DATE OF VISIT	TIME IN	TIME OUT	DID INJURY RESULT IN AGG. OF PRE-EXIST. NON-IND. CONDITION?	WORK RELATED INJURY?	
☐ Acupuncture ☐ Medications ☐ Chiropractor ☐ Physical Therapy				☐YES ☐NO	☐YES ☐NO	☐ INITIAL VISIT ☐ RECHECK ☐ FINAL VISIT

☐ RETURN TO REGULAR WORK – EFFECTIVE DATE: ______________________

☐ RETURN TO WORK WITH FOLLOWING RESTRICTIONS:

- ☐ NO DRIVING OF ANY/COMMERCIAL VEHICLES
- ☐ NO WORKING NEAR MOVING MACHINERY
- ☐ NO PROLONGED SITTING
- ☐ NO PROLONGED STANDING AND WALKING
- ☐ ELEVATE INJURED EXTREMITY TO DECREASE SWELLING
- ☐ SITTING WORK ONLY
- ☐ NO KNEELING OR SQUATTING
- ☐ NO REPETITIVE CLIMBING, BENDING OR TWISTING
- ☐ WEIGHT LIFTING RESTRICTIONS ___________ LBS.
- ☐ SEDENTARY WORK ONLY
- ☐ LIMITED USE OF RIGHT/LEFT HAND/UPPER EXTREMITY
- ☐ LIMITED PUSHING/PULLING/GRASPING OF RIGHT/LEFT HAND
- ☐ REPETITIVE HAND/WRIST WORK LIMITED TO ______________
- ☐ KEYBOARD WORK LIMITED TO ______________
- ☐ CAN WORK IN SPLINT/SUPPORT ONLY/AS NEEDED
- ☐ HAND/NECK/BACK STRETCHING BREAKS FOR ______________
- ☐ ROTATE JOB TASKS TO MINIMIZE CONTINUOUS REPETITIVE HAND/WRIST MOTION
- ☐ NO OVERHEAD LIFTING OR REACHING WITH RIGHT/LEFT UPPER EXTREMITY
- ☐ NO OVERHEAD WORK
- ☐ AVOID PROLONGED NECK FLEXED/EXTENDED POSTURE
- ☐ OTHER: ______________

☐ UNABLE TO PERFORM ANY WORK ACTIVITIES AT THIS TIME. ESTIMATED DURATION: ______________

PHYSICIAN SIGNATURE ______________________   NEXT APPT. DATE ______________

PHYSICAL THERAPY

DATE _______ TIME IN _______ TIME OUT _______   DATE _______ TIME IN _______ TIME OUT _______   DATE _______ TIME IN _______ TIME OUT _______

PAYROLL

INCLUDE DATES OF ABSENCE: FIRST DATE ______________   LAST DATE ______________   # OF HOURS ABSENT ______________

DEPARTMENT

LIGHT DUTY: ☐ IS ☐ IS NOT AVAILABLE AT THIS TIME

RECOMMEND: ☐APPROVED ☐DISAPPROVED ☐PENDING

______________________ / ______________________

Division Head or Designee or Light Duty Coordinator-Print Name / Signature