

## NORTH EAST INDEPENDENT SCHOOL DISTRICT WORK STATUS FORM

Dear Medical Provider: It is our understanding that you are currently treating the employee listed below. In order to obtain accurate work information, please complete the information and return this form to Rena Buley, ADA Coordinator via fax (210) 805-2767.

Part I: General Information (Items 1-7 MUST be completed by the EMPLOYEE for processing.) 2. Date of Birth 3. Employee Job Title 4. Employee's Campus/Department Location 5. Doctor's Name and Degree 6. Clinic/Facility Name: 7. Date Sent to NEISD 8. Employer's Name: North East Independent School District Address: Address: 8961 Tesoro Dr. San Antonio, TX 78217 Fax: (210)-805-2767 City, State, Zip: Phone & Fax: Attention: Michele Matheny (A – L) Leave Management Specialist Emiley Aragon (M - Z) Leave Management Specialist Part II: Work Status Information (Select one option with estimated dates and description of condition 10(c) as applicable) 10. The employee's medical condition: (a) will allow the employee to return to work as of \_ (date) without restrictions – ONLY COMPLETE THIS LINE IF THERE ARE NO RESTRICTIONS INDICATED IN PART III \_\_\_\_ (date) with the restrictions identified in PART III, which are expected to last through \_\_\_\_ (b) will allow the employee to return to work as of \_\_\_\_ (c) has prevented and still prevents the employee from returning to work as of \_ \_\_\_ (date) and is expected to continue through \_\_\_ following describes how the condition prevents the employee from returning to work:\_\_\_ Part III: Activity Restrictions\* (Only complete if 10(b) is checked) 11. RESTRICTIONS SPECIFIC TO (if applicable): 14. LIFT/CARRY RESTRICTIONS (if any): 12 POSTURE RESTRICTIONS (if any): 13. MOTION RESTRICTIONS (if any): L Hand/Wrist R Hand/Wrist Please list Max. Hours per day from a Please list Max. Hours per day from a May not lift/carry objects more than \_\_\_\_ lbs. scale of 0-8 hours. for more than \_\_\_\_ hours per day scale of 0-8 hours. L Arm R Arm ☐ Neck \_ Hours Standing \_\_ Hours Walking ☐ May not perform any lifting/carrying L Leg R Leg ☐ Back Hours Climbing Stairs/Ladders Other: Hours Sitting ☐ L Foot/Ankle ☐ R Foot/Ankle Hours Kneeling/Squatting \_ Hours Grasping/Squeezing 15. MISCELLANEOUS RESTRICTIONS (if anv): Other: ☐ Max. hours per day of work: \_ Hours Bending/Stooping Hours Wrist Flexion/Extension 16. MEDICATION RESTRICTIONS (if any): Sit/Stretch breaks of \_\_\_\_\_ per \_\_\_ Hours Pushing/Pulling Hours Reaching Must take prescription medication(s) ☐ Must wear splint/cast at work Hours Twisting Hours Overhead Reaching Advised to take over-the-counter meds ☐ Medications may cause drowsiness ☐ Must use crutches at all times Hours Other\_\_\_\_ Hours Keyboarding (possible Safety/Driving issues) ☐ No driving/operating heavy equipment Hours Other Can only drive automatic transmission 17. OTHER RESTRICTIONS (if any): IF PATIENT IS A BUS DRIVER, PLEASE INDICATE IF EMPLOYEE CAN DRIVE A SCHOOL BUS. ☐ No work/- \_\_\_\_\_ hours/day work: in extreme hot/cold environments at heights or on scaffolding ☐ Must keep Clean & Dry Elevated No skin contact with: \_\_\_ These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not ☐ Dressing changes necessary at work apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. (Note: these restrictions should be followed outside of work as well.) ☐ No Running Part IV: Treatment/Follow-up Appointment Information 18. Comments: 19. Expected Follow-Up Services Include: ☐ Evaluation by the treating doctor on \_\_\_\_\_ (date) at \_\_\_\_ : \_\_\_ am/pm Referral to/Consult with \_\_\_\_ \_\_\_\_ on \_\_\_ Physical medicine time per week for \_\_\_\_\_ weeks starting on \_\_\_\_ \_\_\_\_\_ (date) at \_\_\_\_ : \_\_\_ \_ on \_\_\_ \_\_\_\_ (date) at \_\_\_\_\_ : \_\_\_\_ am/pm 20. Visit Type: Initial 21. Date/Time of Visit:\_\_\_ ☐ None. This is the last scheduled visit for this employee. At this time, no further medical care is anticipated. ☐ Follow-Up Discharge Time: Employee's Signature: **Doctor's Signature** Date