



EAST BAY REGIONAL PARK DISTRICT
TEMPORARY TRANSITIONAL WORK PROGRAM

**WORK STATUS FORM TO BE COMPLETED BY
*PHYSICIANS NOT WITH KAISER OCCUPATIONAL MEDICINE***

Dear District Employee:

As part of the required paperwork for an occupational illness/injury, please complete the following for the *INITIAL* doctor visit ***AND*** for any visit resulting in a change in your work status.

- Remove this pink instructional sheet from the attached forms for your reference.
- Bring the remaining blue physician instruction sheet and blank work status forms to your doctor exam.
- Ask your physician to complete the work status form for the *initial exam and for any exam resulting in a change in your work status*. Additional copies are attached for future visits. Feel free to photocopy or obtain additional copies from your supervisor.
- ASK DOCTOR'S OFFICE TO FAX COMPLETED WORK STATUS FORM TO RISK MANAGEMENT AT (510) 639-4754 ON YOUR INITIAL DOCTOR VISIT.**
- Keep a copy of the work status form to bring to your supervisor the same or next working day, and keep one for yourself.



**EAST BAY REGIONAL PARK DISTRICT
TEMPORARY TRANSITIONAL WORK PROGRAM**

Dear Physician:

East Bay Regional Park District has an active **TEMPORARY RETURN TO WORK PROGRAM**. We provide temporary transitional work to all employees with short-term disabling injuries. Our Temporary Project assignments can accommodate nearly all work capacities and restrictions.

Please complete the attached required Work Status Form for the *initial* exam and for future exams *only* if there is a change in the patient's work capacities and restrictions. Additional Work Status Forms are provided for your future use.

Please bill accordingly for your services.

Thank you.

Risk Management
East Bay Regional Park District
(510) 544-2164



**WORK STATUS FORM
EAST BAY REGIONAL PARK DISTRICT**

COMPLETE AND FAX WITHIN 24 HOURS TO EBRPD RISK MANAGEMENT: (510) 639-4754

EMPLOYEE: _____	EXAM DATE: _____
DATE OF INJURY: _____	NEXT EXAM DATE: _____
CLAIM #: _____	

The above named employee is released to return to work on _____ under the following work capacities/restrictions:

- FULL DUTY, no restrictions
- MODIFIED WORK, Employee **CAN:** (please check below)

_____ Work FULL TIME _____ Work PART TIME only, _____ hours per day

LIFT/CARRY Up to ___ 5lbs ___ 10 lbs ___ 25 lbs ___ 50 lbs ___ no restriction

PUSH/PULL Up to ___ 5lbs ___ 10 lbs ___ 25 lbs ___ 50 lbs ___ no restriction

STAND/WALK _____ Not at all _____ occasionally _____ frequently _____ no restriction

STOOP/BEND AT WAIST _____ Not at all _____ occasionally _____ frequently _____ no restriction

KNEEL/SQUAT _____ Not at all _____ occasionally _____ frequently _____ no restriction

CLIMB _____ Not at all _____ occasionally _____ frequently _____ no restriction

REACH ABOVE SHOULDER _____ Not at all _____ occasionally _____ frequently _____ no restriction
(LEFT/RIGHT) *Circle*

REPETITIVE USE OF HAND _____ Not at all _____ occasionally _____ frequently _____ no restriction
(LEFT/RIGHT) *Circle*

KEYBOARD _____ Not at all _____ occasionally _____ frequently _____ no restriction

DRIVE _____ Not at all _____ occasionally _____ frequently _____ no restriction

_____ Not at all _____ occasionally _____ frequently _____ no restriction

COMMENTS: _____

- OFF WORK, TOTAL TEMPORARY DISABILITY
Estimated date released to Modified Work/Full Duty: _____

(TO BE SIGNED & DATED BY MEDICAL PROVIDER)

Medical Provider (Please Print)	(SIGNATURE)	Date
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