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 (LEFT/RIGHT) *Circle*	_____Not at all_____occasionally _____frequently _____no restriction
REPETITIVE USE OF HAND (LEFT/RIGHT) *Circle*	_____Not at all _____occasionally _____frequently _____no restriction
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**