QUALITY ELECTRIC INC.

Work Status Report Form

"The Quality Way"
Our People, Our Customers, Our Community

I. General Information			
Injured Worker:		Claim Number:	
Employer Name:		Date of Injury	

II. Work Status Information

Employee is able to return to:

☐ Regular Duty without Restrictions **or** ☐ Modified Duty with Restrictions

Date Released:

III. Physical Capabilities

Check the number of hours the employee can perform the particular task:

	1	2	3	4	5	6	7	8	Not Restricted
Sit	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐	☐	☐	☐	☐

Employee needs to alternate between sit / stand every _____ ☐ Minutes ☐ Hours

Injury Occurred on the: ☐ Left - Side ☐ Right - Side ☐ Both Sides

Does the Employee have a prescription that would hinder the ability to safely perform normal work functions?

☐ No ☐ Yes Type of Drug :

Check the amount of time the injured worker is able to perform the particular task:

	Never	Ocassionally (<33%)	Frequently (33 - 66%)	Continuously (67 - 100%)	N/A
Hand / Wrist Work	☐	☐	☐	☐	☐
Grasping	☐	☐	☐	☐	☐
Pushing / Pulling	☐	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐	☐
Reach Above Shoulder	☐	☐	☐	☐	☐
Bend / Twist	☐	☐	☐	☐	☐
Kneel / Squat	☐	☐	☐	☐	☐
Climb / Stairs	☐	☐	☐	☐	☐
Lifting 1 - 10 lbs.	☐	☐	☐	☐	☐
Lifting 11 - 20 lbs.	☐	☐	☐	☐	☐
Lifting 21 - 50 lbs.	☐	☐	☐	☐	☐
Lifting 50 - 100 lbs.	☐	☐	☐	☐	☐

Total number of hours each day the injured worker may work: _____ *(If not indicated a full work shift will be assumed)*

Projected Date Employee can return to Unrestricted Duties:

The injured worker has been informed of Work Status Report: ☐ No ☐ Yes

Physician's Name: Physician's Signature:

Date:

The entire form must be completed and returned to the employer, even if the injured worker is not authorized to return to work.