Physician's Work Status Report

Sacramento City Unified School District

Employee: _____ **DOI:** _____

Physician's Section: Note: The Sacramento City Unified School District has modified work assignments available for employees injured on the job. Please consider this when completing the following:

Name of Physician: _____ Diagnosis: _____

Physician's Address: _____ Phone: _____

Treatment Today: ☐ Initial Exam ☐ Follow-up ☐ Other

Patient's Condition: ☐ Resolved ☐ Improving ☐ Not Improving ☐ Not Work Related

☐ Permanent & Stationary ☐ No Impairment/No Permanent Disability

Work Status: ☐ Return to Full Duty: ☐ Return to Modified Duty:

☐ Unable to work until: (If modified work is not available, patient is off work until next appointment.)

Work Restrictions:

Frequency	**Never**	**Occasionally**	**Frequently**	**Constantly**	**Activity**	**Yes**	**No**
Hours/day	*0 hrs.*	*Up to 3 hrs*	*3-6 hrs.*	*6 - 8 hrs.*	Dangerous machinery OK?		
Waist-bend/Twist					Wound-clean and dry		
Stand					Sit/stand for comfort		
Walk					Climb		
Sit					Simple Grasp		
Keyboard/10 Key					Firm Grasp		
Reach above shoulders					Precision/manipulation		
Push/pull					Wear splint at work		
Kneel/squat					Other:		

Lifting/carrying/pushing/pulling ability:

Frequency	**Never**	**Occasionally**	**Frequently**	**Constantly**
Hours/day	*0 hrs.*	*Up to 3 hrs*	*3-6 hrs.*	*6 - 8 hrs.*
0 - 10 lbs.				
11-25 lbs.				
26-50lbs.				
>50lbs.				

Other Comments:

M. D.: Please Fax copy to SIA (916) 364-2421

DATE OF NEXT APPOINTMENT: _____ M. D. Signature: _____ Today's Date:_____

Temporary Duty Assignment

(***Complete ONLY if above restrictions prevent return to full duty)***

Employee/ Supervisor Section: *Fax copy to SIA 364-2421 and send original to: Workers' Compensation-Box 840A, SCUSD, 5735 47th Avenue, Sacramento, CA 95824*

Regular Site: _____ Temp Duty Site (if different) _____

This is to confirm that you are restricted to modified or alternate work with doctor restrictions as specified above.
The District is accommodating your restrictions as follows:

- ❑ Working in regular job modified to meet above doctor's restrictions
- ❑ Working in temporary alternate job meeting above doctor's restrictions
- ❑ Other: _____

The District desires to help you during your recovery period by providing you modified, limited and/or alternate work on a temporary basis to assist you with your transition to full duty. However, it is our policy to continue temporary duty for a **maximum of twelve weeks**.

I acknowledge receipt of the physician's restrictions and I am able to accommodate those restrictions and understand the District's policy on temporary duty. Temporary Duty assignment available effective _____.

Supervisor Signature: _____ Date _____

I have provided my supervisor with my physician's restrictions, acknowledge that a temporary accommodation has been made, and that the District's policy is to provide a maximum of twelve weeks on temporary duty.

Questions? Call (916)364-1281(SIA) **Employee Signature**: _____ Date _____

Distribution:

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