



DUTY STATUS FORM

Your cooperation in completing this form is vital to our efforts in determining the work potential or the continuing absence of your patient. It is our desire to assist our employee and your patient to return to work as soon as possible, and to assist him/her in performing essential job functions. The information you provide us is vital to us regarding the following:

- Employee's working without risk of further injury;
- Assessing the provision of a temporary duty assignment, if necessary, that meets the employee's needs and the needs of Charles County Government;
- Assessing the provision of any temporary, reasonable accommodations to aid the employee in performing his/her duties.

****NOTE: ATTACHED IS THE EMPLOYEE'S JOB DESCRIPTION**

Name:	Department:	Job Title:
Is this claimed as Work-Related? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of injury/illness/surgery	

I hereby authorize my treating physician to complete this form:

Signature:	Date:
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THE INFORMATION BELOW MUST BE COMPLETED BY THE TREATING PHYSICIAN

Work Status: Please check one of the following and provide the appropriate date:

<input type="checkbox"/> Return to regular work full time/full duty with no restrictions:	Date:
<input type="checkbox"/> Return to work on modified duty with noted restrictions:	Date:
<input type="checkbox"/> Unable to return work until:	Date:

INDICATE ANY RESTRICTIONS (Job Description is attached)

Activity Allowed Per Day	0 Hours	Up to 3 Hours	Up to 4 hours	Up to 6 hours	No Restrictions	Comment
Sitting						
Driving						
Standing						
Walking						
Climbing						
Bending/Kneeling						
Reaching						
Running						
Pushing/Pulling ____ lbs.						
Lifting/Carrying ____ lbs.						

OTHER RESTRICTIONS

Can the employee drive County vehicles or operate County heavy equipment without restrictions?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the employee under medication that could affect the ability to work/drive?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Limit daily work to:	_____ hours/day
Must the employee perform sedentary work only?	Yes <input type="checkbox"/> No <input type="checkbox"/> Is yes, for how long? _____
Other Recommendations and/or restrictions:	

Has the employee met MMI (maximum medical improvement)? Yes No

Referred to another health care provider/facility? Yes No If so, where: _____

Requested Modified Work Schedule: # of hours per day: _____ # of days per week: _____

As the employee's physician, can you provide reasonable assurance that the employee's condition will not exceed (30) calendar days?

Yes No If no, provide anticipated return to full duty date: _____

TREATING PHYSICIAN ACKNOWLEDGEMENT/SIGNATURE:

I have reviewed the attached Job Description and have indicated restrictions, if any, for the above named individual.

Physician Name:	Physician Signature:
Next Appointment Date & Time:	Date Signed: