FAX OR SEND COMPLETED COPIES OF THIS REPORT TO:

GAB Robins North America, Inc.
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East Hartford, CT 06108
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F: 860-291-9875

Southern Connecticut State University
Department of Human Resources
501 Crescent Street
New Haven, CT 06515

WORKER STATUS REPORT

To Be Completed By Attending Physician

Employee Name (Last) **(First)** **Social Security Number** **Employer**

Southern Connecticut State University

Department **Facility** **Unit** **Address**

Date of Visit:___/___/____ **Date of Injury:**___/___/____ **Claim#** ______ **(Circle)** **Initial Visit** **Follow-up Visit**

Diagnosis/Condition (Brief Explanation): ______ **ICD-9 Code:** ______

Evidence of pre-existing condition: ☐ Yes ☐ No (If yes, explain) ______

Injury/Illness casually related to worker's employment: ☐ Yes ☐ No

Current Treatment Plan ______

Based on my assessment and treatment of this injury, I recommend:

☐ Worker can return to work on ____ / ____ / ______ with no limitations.

☐ Worker can return to modified work on ____ / ____ / ______ with the following functional limitations.

1. In a 8 hour workday, worker can stand/walk:

(Hours at one time)

☐ No restrictions ☐ 6-8 ☐ 4-6 ☐ 2-4 ☐ 0-2

(Total hours during day)

☐ 6-8 ☐ 4-6 ☐ 2-4 ☐ 0-2

2. In an 8-hour workday, worker can sit:

(Hours at one time)

☐ No restrictions ☐ 6-8 ☐ 4-6 ☐ 2-4 ☐ 0-2

(Total hours during day)

☐ 6-8 ☐ 4-6 ☐ 2-4 ☐ 0-2

3. In an 8-hour workday, worker can drive:

(Hours at one time)

☐ No restrictions ☐ 1-3

(Minutes at one time)

☐ 30-60 ☐ 10-30

4. Bend: ☐ Not at all ☐ Occasionally ☐ Frequently
Twist: ☐ Not at all ☐ Occasionally ☐ Frequently
Squat: ☐ Not at all ☐ Occasionally ☐ Frequently
Climb ☐ Not at all ☐ Occasionally ☐ Frequently
Reach: ☐ Not at all ☐ Occasionally ☐ Frequently

☐ These limitations are in effect until ______

5. Weight Handling Frequency

	Number per/hour 15 or more	10-15	1-10	0
Lift and Carry				
a. less than 10 pounds				
b. 10-20 pounds				
c. 20-50 pounds				
d. 50-100 pounds				
e. over 100 pounds				

6. Use of right hand for repetitive:
☐ Single grasping ☐ Fine manipulation
☐ Pushing & Pulling

Use of left hand for repetitive:
☐ Single grasping ☐ Fine manipulation
☐ Pushing & Pulling

7. Use foot/feet for repetitive movement, such as operating foot controls: ☐ Yes ☐ No

Other Instructions or Limitations: ______

If on medication, will medication restrict the employee's ability to work safely? ☐ Yes ☐ No

If yes, explain: ______

Further treatment is needed: ☐ Yes ☐ No

Follow-up appointment date: ______

☐ He/she may not return to work until reevaluated here on ____/____/_____

☐ He/she may return to modified work as shown above and is to be reevaluated by the specialist listed below on ____/____/_____.

☐ He/she may not return to work until reevaluated by the specialist listed below on ____/____/_____.

☐ Physician name ______ Specialty ______ Appt. date: ______

☐ Non Physician provider name ______ Specialty ______ Appt. date: ______

Provider name (print) ______
Provider location ______
Provider's signature ______
Date ______ License No. ______

AUTHORIZATION TO RELEASE INFORMATION

I hereby consent to the release of the above information to GAB Robins North America, Inc. the payer or the insurance company(if any) responsible for paying my Worker's Compensation claim and my employer.

Injured worker's signature ______

Date: ______