Archdiocese of New Orleans
Employee Work Status Form

Employee Name: _______________________________________ Date: ___________________________

Physician’s Name: ______________________________________ Phone Number: ___________________

TO BE COMPLETED BY PHYSICIAN

After reviewing the attached job description and the specific tasks within the job description, please complete either (A) or (B) as appropriate and sign and date below.

(A) The above named employee has been released by the above named physician to return to Full Duty as of _________________ (Date) with NO RESTRICTIONS.

(B) The above named employee has been released by the above named physician to Return to Work on _________________ (Date) WITH THE FOLLOWING RESTRICTIONS:

Check applicable boxes and provide limitations/restrictions:

☐ Lifting (Max weight in lbs) _____ lbs  ☐ Walking _______________ (hours per day)
☐ Repetitive Lifting _____lbs  ☐ Standing _______________ (hours per day)
☐ Carrying ________lbs  ☐ Sitting _______________ (hours per day)
☐ Pushing/Pulling _________ lbs  ☐ Crawling _______________ (hours per day)
☐ Pinching/Gripping ________ lbs  ☐ Kneeling _______________ (hours per day)
☐ Reaching over head  ☐ Squatting _______________ (hours per day)
☐ Reaching away from body  ☐ Climbing _______________ (hours per day)
☐ Repetitive Motion Restrictions: ______________________________________________________________________
                                                                                                           __________________________________________________________________________________________________
☐ Other Restrictions: ________________________________________________________________________________
                                                                                                           __________________________________________________________________________________________________

These limitations/restrictions are: ☐ Temporary limitations/restrictions through _______________.
                                                                                                           ☐ Permanent limitations/restrictions

My signature indicates that I have read and understand the employee’s job description and the listed tasks within the job description and that my findings are based on my medical assessment of this employee’s ability to perform the job duties.

__________________________________________________________________________  ____________________________________________________________________________  _____________
Physician’s Signature  Date

Physician’s Name (Please Print)

(mem 8/2019)