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

☐ Repetitive Lifting _____lbs

☐ Carrying ________lbs

☐ Pushing/Pulling _________lbs

☐ Pinching/Gripping _______lbs

☐ Reaching over head

☐ Reaching away from body

☐ Walking _______________ (hours per day)

☐ Standing _______________ (hours per day)

☐ Sitting _________________ (hours per day)

☐ Crawling _______________ (hours per day)

☐ Kneeling _______________ (hours per day)

☐ Squatting ______________ (hours per day)

☐ 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 Name (Please Print) | Physician's Signature | Date

(mem 8/2019)