ASPIRUS
Passion for excellence. Compassion for people.

Work Status Form/Return to Work Updates

Patient's Name:	Date of Birth:

TO BE COMPLETED BY ATTENDING PROVIDER

Today's Exam DATE:	**Date of Injury/Illness:**	**Next Exam DATE:**

Diagnosis:

☐ Return to work with **NO** limitations on this **DATE**: _____

☐ Completely incapacitated at this time - off work with Re-evaluation **DATE**: _____

☐ Return to work with the **temporary** limitations listed below starting and ending on:

Limitations **Start DATE**: _____ Limitations **End DATE**: _____

☐ Return to work with **permanent** limitations: **Start DATE**: _____

Restrictions:

☐ **SEDENTARY WORK:** Requires little or no walking/standing and require lifting of 5 pounds or less.

☐ **LIGHT WORK:** May require significant walking/standing, individuals may lift 5 pounds regularly and 10 pounds maximum.

☐ **MEDIUM WORK:** May require significant walking or standing. Individuals may lift 20 pounds regularly and up to 50 pounds maximum.

☐ **HEAVY WORK:** Individual may lift 50 pounds regularly and up to 100 pounds maximum.

☐ **VERY HEAVY WORK:** Individual may lift regularly and up to 100 pounds.

LIMITATIONS

	Yes	**No**
Stand		
Walk		
Sit		
Drive		
Bend		
Squat		
Kneel		
Climb		
Type		
Reach		

OTHER INSTRUCTIONS AND/OR LIMITATIONS (Hours restrictions/Overtime restrictions):

Physician's Name:

Physician's Signature:	Date of Signature:

- **Please do not send this document to your supervisor or department.**
- **It should be returned to Leave Management Services at:**
  - **Leave Management Services, 135 S. Gibson St., Medford, WI 54451**
  - **E-mail: leavemanagementservices@aspirus.org**
  - **Phone: 715-748-8115 Fax: 715-841-4300**