Work Status Report

Patient: ________________________________ Employer: ____

SSN: ________________________ Date of Birth: ___________________ Date of Injury: _________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the Mississippi Municipal Service Company (MMSC) and all physicians or medical providers to release and disclose to MMSC and/or my employer all requested information, records, and copies (including, but not limited to, a completed Work Status Report) regarding my condition, diagnosis, treatment, prognosis, and evaluation for the above specified accident/injury/illness, and any impairment or disability resulting therefrom. I further authorize the disclosure of such information and medical/surgical records to, and discussion of my condition, diagnosis, treatment, prognosis, evaluation, and any resulting impairment or disability with MMSC or my employer. Such information, records, and copies may be disclosed and released by mail, personal delivery, facsimile transmission, verbally, or by such other means as requested. Photocopies of this authorization shall be effective as the original.

Employee Signature: ____ Date: ____________________

Diagnosis or Condition:

WORK STATUS AND FOLLOW-UP TREATMENT

☐ Return To Regular/Full Duty Work Date: _________
(No Limitations or Restrictions)

☐ Reached Maximum Medical Improvement:
Date: __________

☐ Follow-up Or Referral Appointment:
with ______________________________________ Date: __________

☐ Return To Work In Restricted/Modified Duty (See Below)
Assignment With The Following Restrictions: ↴

☐ Other:

Recommended Treatment Plan:

RESTRICTIONS (Please Check/Complete All Appropriate Boxes)

☐ **LIFTING ABILITIES:** may lift up to: 0 10 20 25 30 35 40 50 or ____ pounds _____ times/hr ______ hours/shift

☐ **SITTING ABILITIES:** may sit: 0 20 30 40 50 or ____ minutes/hour ______ hours/shift

☐ **STANDING/WALKING ABILITIES:** _______ hours/shift ______ minutes/hour

☐ **CARRYING ABILITIES:** ______ pounds ______ times/hour

☐ **BENDING/TWISTING/STOOPING ABILITIES:** ______ hours/shift

☐ **PUSHING/PULLING ABILITIES:** ______ pounds

☐ **ENDURANCE ABILITIES:** _______ hours/shift ______ days/week

☐ **REPETITIVE ABILITIES:** No repetitive movement of ___________________________________

☐ **PROTECTION:** Change in Personal Protection Equipment: _________________________________

☐ **NO REACHING ABOVE SHOULDER HEIGHT**

☐ **NO REACHING BELOW WAIST**

☐ **NO REACHING BELOW KNEES**

☐ **DRY WORK ONLY**

☐ **NO EXPOSURE TO DUST/FUMES**

☐ **OTHER:**

Physician's Signature: ____ Date: ___________________

Physician's Address ____ Telephone: ___________________

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