UNIVERSITY OF OREGON
EMPLOYEE STATUS REPORT

Employee Name _____ **Date of Next Appointment** _____

NOTE: This form is used to assist the University in providing employees with reasonable accommodations and/or modified work. **PLEASE DO NOT INCLUDE MEDICAL DIAGNOSIS**

Current Status (check one only):

[ ] Released to regular work without restrictions Date: _____
[ ] Released to modified work (indicate restrictions below) Date: _____
[ ] Not released to any form of work* Date: _____
*Estimated date of release to work: _____

Restrictions (fill in the blank, check box or circle restrictions for each activity):

In a work day, limitations include: **SIT** _____ hours; **STAND** _____ hours; **WALK** _____ hours
At one time, limitations include: **SIT** _____ hours; **STAND** _____ hours; **WALK** _____ hours

	67-100% Continuously	34-66% Frequently	6-33% Occasionally	1-5% Intermittently	0% Never
BEND/STOOP	[ ]	[ ]	[ ]	[ ]	[ ]
CLIMB	[ ]	[ ]	[ ]	[ ]	[ ]
CRAWL	[ ]	[ ]	[ ]	[ ]	[ ]
PUSH	[ ]	[ ]	[ ]	[ ]	[ ]
PULL	[ ]	[ ]	[ ]	[ ]	[ ]
REACH (above shoulder)	[ ]	[ ]	[ ]	[ ]	[ ]
SQUAT	[ ]	[ ]	[ ]	[ ]	[ ]
LIFT/CARRY, PUSH/PULL					
Up to 10 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]
11-20 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]
21-30 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]
31-40 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]
41-50 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]
51-100 lbs.	[ ]	[ ]	[ ]	[ ]	[ ]

Use of Hands:	Repetitive Action	Simple Grasping	Pushing/Pulling	Fine Manipulation
Right	C F O I N	C F O I N	C F O I N	C F O I N
Left	C F O I N	C F O I N	C F O I N	C F O I N

C = Continuously 67-100% F = Frequently 34-66% O = Occasionally 6-33% I = Intermittently 1-5% N = Never 0%

Is the commute (as a driver or passenger) to work within the physical capacities of the employee? YES NO

Estimated time for modified duty: _____ **Medically Stationary?** Yes (date)_____ No_____
Please list any restrictions you believe will be permanent and affect the ability of the employee to perform work:

_____

Please list side effects from medication, prescribed for use during work hours, that may impair employee's ability to safely perform work tasks: _____

Comments: _____

Print Physician's Name: _____ Telephone: _____

Physician's Signature: _____ Date: _____

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