University of Oregon

HR Employee Status Report (ESR)

Required 2 days prior to return to work date

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 Work Status (check one only):

[ ] **Released to regular work without restrictions** Status from (date): _____

[ ] **Not released to regular work** Status form (date): _____ to: _____

[ ] **Released to modified work** (indicate restrictions below) Status from (date): _____ to: _____

Total work hours: _____ hours/day **Medically Stationary:** [ ] Yes Date: _____

Restrictions:

Lift/carry/push/pull

	One-time	***< 1/3 of work day***	***1/3-2/3 of workday***	***>2/3 of work day***	***Duration***	
Lift:	_____ lbs.	_____ lbs.	_____ lbs.	_____ lbs.	___ hrs/day	___ hrs/one time
Carry:	_____ lbs.	_____ lbs.	_____ lbs.	_____ lbs.	___ hrs/day	___ hrs/one time
Push:	_____ lbs.	_____ lbs.	_____ lbs.	_____ lbs.	___ hrs/day	___ hrs/one time
Pull:	_____ lbs.	_____ lbs.	_____ lbs.	_____ lbs.	___ hrs/day	___ hrs/one time

Activity

Stand:	___ hrs/day	___ hrs/one time	***Twist:***	___ hrs/day	___ hrs/one time	***Crawl:***	___ hrs/day	___ hrs/one time
Walk:	___ hrs/day	___ hrs/one time	***Climb:***	___ hrs/day	___ hrs/one time	***Crouch:***	___ hrs/day	___ hrs/one time
Sit:	___ hrs/day	___ hrs/one time	***Bend:***	___ hrs/day	___ hrs/one time	***Balance:***	___ hrs/day	___ hrs/one time
Drive:	___ hrs/day	___ hrs/one time	***Above shoulder reach :***	___ hrs/day	___ hrs/one time	***Below shoulder reach:***	___ hrs/day	___ hrs/one time
Kneel:	___ hrs/day	___ hrs/one time						

Hand Use ***Foot Use***

Fine actions:	___ hrs/day L hand	___ hrs/day R hand	***Raise:***	___ hrs/day L foot	___ hrs/day R foot
Key boarding:	___ hrs/day L hand	___ hrs/day R hand			
Grasp:	___ hrs/day L hand	___ hrs/day R hand	***Push:***	___ hrs/day L foot	___ hrs/day R foot

Is the commute (as a driver or passenger) to work within the physical capacities of the employees: [ ] Yes [ ] No

Other restrictions or information that you believe will be permanent and affect the ability of the employee to perform work:

_____

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

Additional comments: _____

_____

Print Medical Provider's Name: _____Telephone: _____

Address: _____

Medical Provider's Signature: _____ Date: _____

Return completed form via fax to UO Human Resources:

Medical Leaves Coordinator

Phone (541) 346-2950 **Fax** (541) 346-2548