

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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