Employee Status Form

CO-WORKER NAME: _____DEPT CODE: _____ CO-WORKER ID # _____

DATE OF SERVICE: _____ DATE OF INJURY: _____

DESCRIPTION OF INJURY/ILLNESS:_____ INITIAL INJURY/TREATMENT Yes / No

TRANSITIONAL DUTY AVAILABLE

To assist United Airlines in understanding our co-worker's current work restrictions please indicate all physical restrictions (if any) so we can ensure proper placement on light duty.

- ❑ PATIENT HAS NO RESTRICTIONS AS OF DATE:_____
- ❑ PATIENT HAS REACHED MAXIMUM MEDICAL IMPROVEMENT AS OF DATE:_____
- ❑ PATIENT IS RELEASED WITH THE FOLLOWING PHYSICAL CAPABILITIES UNTIL DATE: _____

ACTIVITY	MAY NOT PERFORM	UP TO 2 HOURS	2 TO 4 HOURS	4 TO 6 HOURS	8 HOURS OR MORE
BODY MOVEMENTS					
Stand					
Walk					
Sit					
Bend / Twist					
Kneel / Squat / Crawl					
Head / Neck Movement					
Outward Reach Arms *					
Outward Reach Wrist / Hands *					
Reach above Shoulder *					
Repetitive Hand Use					
Grip *					
Other:					

ACTIVITY	MAY NOT PERFORM	UP TO 2 HOURS	2 TO 4 HOURS	4 TO 6 HOURS	8 HOURS OR MORE
LIFT/CARRY					
Up to 20 lbs.					
20 to 45 lbs.					
45 to 70 lbs.					
PUSH/PULL					
Up to 20 lbs.					
20 to 45 lbs.					
45 lbs. or Greater					
MISCELLANEOUS	**NO**				**YES**
Full Visual Acuity, Color Discrimination and full Field Vision					
Ability to Hear					
Drive and Operate Equipment					
Climb and Work at Heights					
Cane or Walker required					

***Above restriction(s) applies to:** ____**Left** ____**Right** ____**Both**

CLARIFICATION OF ABOVE LIMITATION(S) and PROGRESS: _____

_____

ADDITIONAL COMMENTS, REFERRALS, etc.: _____

_____

Physician's Signature: _____ **Date:** _____

Physician's Name: _____**Fax:** _____ **Phone:** _____

Date of Next Examination:_____ **Anticipated Return to Work/MMI/P & S Date:** _____

Fax to United Employee Service Center at 847-700-9533 immediately following each visit