Complete and print.

Reset Form

Medical Status Report for Mayo Clinic Employees

Instructions to Provider: Complete the information below as it relates to the individual's ability to return to work. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. §1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Print and sign this document, then provide a copy to the employee for submission. This form can be scanned into the electronic medical record if requested by completing health care provider.

Instructions to Employee: Promptly submit a copy of this document utilizing the Employee Incident Reporting and Medical Leave Requests tile in the timekeeping system and available at https://ohs-prod-portalui.mayo.edu/RcsHome. Select **Work Restrictions** under the **Send new general inquiry related to** section on the **My Communications** tile. Complete the Send New Inquiry form and use the "Choose Files" button to attach the completed and signed Medical Status Report.

Employee Information

Employee Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*	Employee ID

Injury or Illness Information

Is this a work-related injury? ☐ Yes ☐ No ☐ Unknown	Injury or Illness Onset Date (as specific as possible)	ICD-10 Code

Diagnosis Related to Injury, Illness, or Surgery

Treatment Plan

Next Appointment Date *(mm-dd-yyyy)*:	**Surgery or Procedure Date** *(mm-dd-yyyy)*:

Return to Work Plan Complete all information as appropriate.

☐ Unable to return to work from *(mm-dd-yyyy)*: through *(mm-dd-yyyy)*:

☐ Able to return to work with the restrictions listed below from *(mm-dd-yyyy)*: through *(mm-dd-yyyy)*:

☐ Able to return to work without restrictions on *(mm-dd-yyyy)*:

Number of work hours per day: Number of days per week: Other (eg, schedule limitation):

Restrictions Check only those items that apply. Add additional restrictions in the blank cells.

Frequency key (based on an 8-hour shift per day)

Rarely: less than 30 min/day Occasionally: 30 min – 2.5 hours/day Frequently: 2.5 – 5.5 hours/day Continuously: 5.5 or more hours/day

	Unable to Perform	Rarely (< 5%)	Occasionally (6–33%)	Frequently (34–66%)	Continuously (67–99%)		L	R	Unable to Perform	Rarely (< 5%)	Occasionally (6–33%)	Frequently (34–66%)	Continuously (67–99%)
Stand, walk	☐	☐	☐	☐	☐	Lift, carry	☐	☐	☐	lbs	lbs	lbs	lbs
Twist, turn	☐	☐	☐	☐	☐	Push, pull	☐	☐	☐	lbs	lbs	lbs	lbs
Bend, stoop	☐	☐	☐	☐	☐	Reach above shoulder	☐	☐	☐	☐	☐	☐	☐
Squat, kneel, crawl	☐	☐	☐	☐	☐	Repetitive grasp or pinch	☐	☐	☐	☐	☐	☐	☐
Climb	☐	☐	☐	☐	☐	Keyboard operation	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐

Additional Restrictions

☐ Sedentary work or activities only	☐ Keep wound clean and dry	☐ No working in patient care environment or room
☐ Able to alternate sitting, standing, walking as needed	☐ No work with latex products	☐ No contact with patients
☐ No operating power equipment	☐ No assaultive or physical control situations	☐
☐ No working at heights	☐ No complex- or safety-sensitive decision-making	☐
☐ No driving work vehicles	☐ No hands-on patient care	☐

Estimated time to return to work unrestricted: ☐ 2 weeks or less ☐ 3–8 weeks ☐ More than 8 weeks ☐ Unknown

Additional Comments

Provider Information

Medical Facility		Phone	Fax
Provider Signature ▶ Signature Required	Date *(mm-dd-yyyy)*	Provider Printed Name *(First, Middle, Last)*	

Print

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