PHYSICIAN'S WORKER STATUS REPORT
For Employees of The State of Connecticut
PER-WC-208 REV. 09/09

State of Connecticut
Department of Administrative Services
Workers' Compensation Division

INSTRUCTIONS

1. To be completed (both pages) by Initial Care Physician or Attending Physician and provided to the injured worker as part of the office visit.
2. Mail or fax copy to State of Connecticut Third Party Claim Administration Company within 24 hours of the office visit.
   - GAB Robins North America, Inc., 800 Connecticut Boulevard, East Hartford, Connecticut 06108
     Fax: (860) 291-9875
     Phone: (860) 256-3400

_____ _____
Employee Name State Agency and Location

Date of Office Visit: _____/_____/_____ Date of Injury: _____/_____/_____ Initial Visit ☐ Follow-Up Visit ☐

TIME ARRIVED:_____ TIME DEPARTED:_____ Injury/Illness causally related to worker's employment? Yes ☐ No ☐

Diagnosis: _____

Evidence of pre-existing condition: Yes ☐ No ☐ (If Yes, explain): _____

Treatment Plan: _____

Follow-Up Visit/Treatment needed with this office? Yes ☐ No ☐ If Yes: Next appointment date: _____ /_____ /_____

Referral to Specialty needed? Yes ☐ No ☐ If Yes, Type of Specialty:_____

Referral Appointment made? Yes ☐ No ☐ Name: _____ Date:_____/_____/_____

Patient Work Disposition (Please check the appropriate work disposition)

The State of Connecticut makes every effort to return an injured worker to restricted duty employment.

1. _____ Patient is capable of full and regular duty (effective date) _____/_____/_____ (Skip items a-d below).
2. _____ Patient is not capable of any form of gainful employment (as of date) _____/_____/_____
3. _____ Patient is capable of working a Recoup Post. (Department of Correction only) (effective date) _____/_____/_____
4. _____ Patient is capable of modified/restricted work as indicated below (effective date) _____/_____/_____

Note: In terms of a normal work day; Occasionally = Up to 33%, Frequently = Up to 66%, and Continuously = Up to 100%

	Never	Occ.	Freq.	Cont.	No Restrictions
a. Patient is able to:					
Bend	☐	☐	☐	☐	☐
Squat	☐	☐	☐	☐	☐
Kneel	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐
Climb Stairs	☐	☐	☐	☐	☐
Twist	☐	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐	☐
Lift above shoulder	☐	☐	☐	☐	☐
Reach above shoulder	☐	☐	☐	☐	☐

Note: In terms of a normal work day; Occasionally = Up to 33%, Frequently = Up to 66%, and Continuously = Up to 100%

	Never	Occ.	Freq.	Cont.	No Restrictions
b. Patient is able to lift					
Up to 10lbs	☐	☐	☐	☐	☐
11-24lbs	☐	☐	☐	☐	☐
25-34lbs	☐	☐	☐	☐	☐
35-50lbs	☐	☐	☐	☐	☐
51-74lbs	☐	☐	☐	☐	☐
75-100lbs	☐	☐	☐	☐	☐

	Never	Occ.	Freq.	Cont.	No Restrictions
c. Patient is able to carry					
Up to 10lbs	☐	☐	☐	☐	☐
11-24lbs	☐	☐	☐	☐	☐
25-34lbs	☐	☐	☐	☐	☐
35-50lbs	☐	☐	☐	☐	☐
51-74lbs	☐	☐	☐	☐	☐
75-100lbs	☐	☐	☐	☐	☐

	Never	Occ.	Freq.	Cont.	No Restrictions
d. Patient is able to use hands					
(left ☐ right ☐ both ☐)					
Keyboard Typing	☐	☐	☐	☐	☐
Grasping	☐	☐	☐	☐	☐

e. Is patient involved with treatment and/or medication that might affect his/her ability to work?

☐ No

☐ Yes: Explanation: _____

f. Will patient be required to use any assistive devices or braces while working regular or modified/restricted duty?

☐ No

☐ Yes: Explanation:_____

The above Restrictions are in effect until: _____/_____/_____

Physician Comments: _____

_____

_____

Physician Name &Address: _____ **Signature:**_____
(Please Print)

_____ **Date:** _____/_____/_____

_____

Authorization to Release Information

I hereby authorize this Medical Provider to release my information acquired in the course of my examination or treatment for the above injury to my employer or it's representative.

_____ _____ _____/_____/_____

Patient's Name (Print) **Patient's Signature** **Date**