



Health Status Report

P.O. Box 668, Holbrook, Arizona 86025

Please address any questions concerning the Health Status Report to Risk Management (928)524-4033.

Section I: Instructions to the Health Care Provider

Please complete this Health Status Report. We may be able to place this employee in a temporary modified duty assignment. Upon receipt of the report and based upon your assessment, we will begin the process of determining the appropriate assignment. This report need only address the issue presented.

Date of Report: _____ Employee SSN or ID#: _____

Employee Name (First, Middle, Last): _____

Job Title: _____ Work Location: _____

Date Injury/Illness Began: _____ Is this an Industrial Injury? Yes No

Nature of Condition: _____

Prognosis: _____

Estimated Date of Recovery: _____ Date of Next Appointment: _____

Part A: Work Status

- May work full duty with no restrictions
- May work _____ hours/day, approximately how long? _____
- Off work, approximately how long? _____
- Discharged
- Restrictions are permanent/no improvement expected

Part B: Prescribed Medications

1. Is the employee taking or prescribed any medication Yes No
2. If the employee is taking or prescribed medication, is the medication a narcotic or other mind-altering medication? Or medication that would affect the employee's ability to his/her job? _____



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3. Are there any restrictions for the employee to operate machinery, equipment, vehicles or weapons due to current mental state, physical state or prescription medication? _____

Part C: Employee's Functional Capacity (Check only those that apply):

- No lifting, no pushing, no pulling, no running
- No lifting over _____ 10 _____ 20 _____ 50 _____ ? pounds
- No repetitive bending/twisting Body part _____
- No repetitive motion to injured part (i.e., leg, arm) _____
- No climbing _____ ladders _____ stairs
- No work reaching above the shoulder
- No inmate contact (Detention)*
- No hand to hand combat (NCSO) No
- No operation of a motor vehicle
- operation of hazardous equipment
- Work capacity Can sit _____ hours/day Can stand _____ hours/day Can walk _____ hours/day
- Can work _____ hours/day
- Unable to carry firearms
- Visual limitations (What is the limitation): _____
- Psychological limitations (What is the limitation): _____
- Environmental limitations (What is the limitation): _____
- Additional Limitations Cold Heat Allergies _____

Comments: _____

Provider's Name: _____

Address: _____ Telephone No.: _____

Provider's Signature: _____ Date: _____

*(Note: Inmate contact includes physical contact, direct contact or incidental contact. It also includes contact necessary to use in responding to emergencies occurring at the facility or contact required to prevent physical contact between individuals in the facility. This includes, but is not limited to, physical contact necessary to evacuate or lock-down the facility, apply restraints, prevent fights, respond to security threats, maintain security, render medical aid, prevent inmates from harming themselves or others and complete defensive training.)