MADISON METROPOLITAN SCHOOL DISTRICT
WORK STATUS REPORT/MEDICAL SERVICE FORM

LIGHT DUTY WORK WILL BE ACCOMMODATED FOR ALL CONDITIONS

Please reach out to Workers Compensation Specialist at (608) 663-1745 with any questions or concerns

Fax Immediately to: 608-204-0346 (Custodians please also fax to 608-204-0374)

Directions: You are required to notify your treating provider that MMSD will accommodate all light duty work. To expedite prompt claim handling, this complete form is to be returned to the Madison Metropolitan School District either on the same day of your appointment. Be sure to give this form to your supervisor and request that the supervisor forward the paperwork to the Benefits Division.

EMPLOYER INFORMATION	
Madison Metropolitan School District	Phone: 608-663-1692
545 W Dayton Street, Room 133, Madison, WI 53703	Fax: 608-204-0346

EMPLOYEE INFORMATION (to be completed by the employee)			
Name			
Home/Cell Phone		Date of Birth	
B Number		Social Security Number (required)	
Date of Injury		Time of Injury	am/pm

MEDICAL INFORMATION (to be completed by the treating licensed physician/medical doctors) LIGHT DUTY WORK WILL BE ACCOMMODATED FOR ALL CONDITIONS					
Treatment Received At	☐ Clinic ☐ Urgent Care ☐ Emergency Room				
Date of Exam		Time of Exam		Date of Follow Up	
Diagnosis					
Work Capabilities	☐ **Full duty** as of _____(date) ☐ **Light Duty Capabilities** through _____(date)				
	Walking: ☐ Full abilities ☐ 4-7 hours ☐ 1-4 hours ☐ Under 1 hour **Lifting:** ☐ 30+ lbs ☐ 21-30 lbs ☐ 11-20 lbs ☐ 0-10 lbs	**Standing:** ☐ Full abilities ☐ 4-7 hours ☐ 1-4 hours ☐ Under 1 hour **Limited Ability:** ☐ Hold Objects ☐ Grip ☐ Type/Keyboard ☐ Other_____ _____	**Sitting:** ☐ Full abilities ☐ 4-7 hours ☐ 1-4 hours ☐ Under 1 hour **Limited Ability:** ☐ Bend ☐ Squat ☐ Kneel ☐ Other_____ _____	**Climbing:** ☐ Full abilities ☐ 4-7 hours ☐ 1-4 hours ☐ Under 1 hour **Environmental Exposure:** (ex. heat, cold, lights, etc.) (please specify) _____ _____	**Traveling:** Public Transit ☐ Yes ☐ No Drive Vehicle ☐ Yes ☐ No **Potential Side Effects:** from medications that could impact RTW (please specify) _____ _____
	☐ **Other**_____ through _____(date) Comments:				
Treatment Plan	Expected healing time: Days_____ Weeks_____ Months_____ Other_____ ☐ Must return for re-evaluation on _____(date) ☐ To receive PT/OT services at the rate of _____ time per week for _____ weeks ☐ Inpatient surgery scheduled for _____ at ____:_____ ☐am ☐ pm ☐ Outpatient surgery scheduled for _____ at ____:_____ ☐am ☐ pm ☐ No further care required. Discharge as of _____(date)				
Physician Name		Facility Name			
Facility Address		Facility Phone Number			
Physician Signature		Date			

Travelers Insurance PO Box 3205 Naperville, IL 60655 800-832-7839