



Manchester Public Schools

Office of Human Capital & Talent Development

Benefits Office

45 North School Street

Manchester, Connecticut 06042

Tel: (860) 647-3458 / Confidential Fax: (860) 647-4551

WORK STATUS FORM

EMPLOYEE	Name of Employee (Please Print or Type):
	Employee's Occupation/Job Title:

HEALTH CARE PROVIDER	THE FOLLOWING MUST BE COMPLETED AND RETURNED TO HUMAN RESOURCES PRIOR TO YOUR RETURN TO WORK. PLEASE DO NOT RETURN TO WORK UNTIL YOU RECEIVE CLEARANCE FROM HUMAN RESOURCES.	
	Date of Visit:	
	Diagnosis/Condition:	
	Return to Full Duty (No Restrictions) On: _____	
	Return to Restricted Duty On: _____ To: _____ ~ Please Indicate Restrictions Below ~	
	Squatting: Yes / No / Minimal Crawling: Yes / No / Minimal Kneeling: Yes / No / Minimal Bending/Twisting: Yes / No / Minimal Climbing: Yes / No / Minimal Walking: Yes / No / Minimal Sitting: Yes / No / Minimal Other (Please Describe): _____	Overhead Lifting: ☐ Left ☐ Right; Not > __ Lbs. Reaching: ☐ Left ☐ Right; Not > __ Lbs. Pushing: ☐ Left ☐ Right; Not > __ Lbs. Pulling: ☐ Left ☐ Right; Not > __ Lbs. Lifting Weight: ☐ Left ☐ Right; Not > __ Lbs. Repetitive Grasping: ☐ Left ☐ Right; Not > __ Lbs. No Repetitive Use of: ☐ Left ☐ Right _____
Name of Health Care Provider:		
Specialty:		
Address:		
City:	State:	Zip:
Telephone Number:		

Signature of Health Care Provider:	Date:
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