Aloha office: 971-215-6333 Fax – 971-215-3041
RA1 office: 503-613-9646 Fax – 503-613-7858
RA3 office: 971-214-8422 Fax – 971-214-8607
Jones Farm: 503-264-8315 Fax – 503-264-8315
Hawthorn Farm: 503-696-2262 Fax – 503-696-2754

Oregon Intel Health Services
Treatment Status Form
RETURN TO WORK ACTIVITY STATUS FORM

Name:	WWID:	EE Contact #:
Shift:	Fab:	Manager:
Reason for Health Services Visit:		
Appointment authorized by (OHN/MCM):		

Remainder: TO BE COMPLETED BY TREATING HEALTH CARE PROVIDER:

Date of Injury:	Date of initial treatment:

Name of Provider:	Specialty:
Brief description of condition/illness/or diagnosis:	
Please list all treatment/therapy/medication & dosage prescribed for this condition.	

Do you feel this injury or illness is the result of an occupational work related injury/illness? □ **yes** □**no**

Complete (1) or (2) or (3) or (4) BELOW:

1. **Employee may return to work *WITHOUT* restrictions effective ____.**
2. **Employee is medically stationary ____ (date) with_________________ percentage of impairment.**
3. **Employee may not return to work until ________________________________(date).**
4. **Employee may return to work *WITH* restrictions effective _________________________ (date): *SEE BELOW AND CHECK ALL THAT APPLY.***

❒ ***Can*** **wear bunny suit, booties, dryden helmet**
❒ ***Can*** **work _____________ hours per day**
❒ ***Can*** **work _____________ days/week**
❒ ***Can*** **carry under ________________ lbs. ________________ times per hour**
❒ ***Can*** **stoop, twist, bend __________________ times per hour**
❒ ***Can*** **lift over shoulder level ____________________ times per hour**
❒ ***Can*** **stand for ______________minutes per hour**
❒ ***Can*** **walk _________________ minutes per hour**
❒ ***Can*** **sit for _________________minutes per hour**
❒ ***Can*** **perform gripping and twisting __________________ times per hour**
❒ ***Can*** **perform keyboarding for_____minutes per hour with ____________________ hand/hands (mark: right, left, or both)**
❒ ***Can*** **perform mousing for______minutes per hour with ____________________ hand/hands (mark: right, left, or both)**
❒ ***Can*** **walk using crutches/ cane**
❒ ***Can*** **operate a motor vehicle or machinery operations (circle all that apply)**
❒ ***Can*** **use a microscope**
❒ ***Must*** **wear splint/ cast**
❒ ***Avoid*** **exposure to (noise, cold, etc) ____**
❒ ***Other*** **____**

These restrictions are to stay in place until:	Next appt date & time:
Signature of Provider:	Phone #: Fax#:
Provider (please print)	Date: