Arizona Department of Corrections Rehabilitation and Reentry

Health Status Report

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, and must be submitted to the Occupational Health Nurse (OHN). If you have any questions, please contact:*

EMPLOYEE NAME *(Last, First M.I.) (Please print)*	EMPLOYEE IDENTIFICATION NUMBER

JOB TITLE	WORK LOCATION	DATE *(mm/dd/yyyy)*

DATE INJURY/ILLNESS BEGAN *(mm/dd/yyyy)*	IS THIS AN INDUSTRIAL INJURY/ILLNESS? ☐ Yes ☐ No
NATURE OF CONDITION*	**PROGNOSIS***
ESTIMATED DATE OF RECOVERY *(mm/dd/yyyy)*	DATE OF NEXT APPOINTMENT *(mm/dd/yyyy)*

WORK STATUS:

☐ May work full duty with no restrictions starting on: _____

☐ **May work modified light duty starting** _____ **Approximately how long?*** _____

☐ **May work** _____ **hours/day starting on** _____ **Approximately how long?*** _____

☐ Off work, starting _____ Approximately how long? _____

☐ Discharged from care ☐ No permanent impairment

☐ Restrictions are permanent/no improvement expected

EMPLOYEE'S FUNCTIONAL CAPACITY: ***(Check only those that apply)***

☐ No pushing, No pulling, No running

☐ No lifting over _____ pounds

☐ No repetitive bending/twisting

Body Part _____

☐ No repetitive motion to injured part *(i.e., leg, arm)* _____

☐ No climbing _____ ladders _____ stairs _____

☐ Able to traverse _____ stairs to enter a room or building

☐ No inmate control/intervention activities

☐ No operation of a motor vehicle

☐ No operation of hazardous equipment

☐ No work reaching above the shoulder

☐ Workday Capacity

Can sit _____ hours/day

Can stand _____ hours/day

Can walk _____ hours/day

☐ Visual Limitations *(What is the limitation)*

_____

☐ Psychological Limitations *(What is the limitation)*

_____

☐ Environmental Limitations *(What is the limitation)*

_____

COMMENTS

PROVIDER NAME *(Last, First M.I.) (Please print)*	ADDRESS *(Street no., city, state, zip code)*	TELEPHONE NUMBER *(area code)*

SIGNATURE	DATE *(mm/dd/yyyy)*

This completed form must be provided to the OHN:

OHN's Fax Number *(area code)* _____ OHN's Telephone Number *(area code)* _____

The Genetic information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA, Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.