MEDICAL STATUS REPORT

Phone: 708/332-3573 or 708/332-3575 ***Fax: (708) 332-4349***

EMPLOYEE INFORMATION

PIN _____

Name: _____ SS#: _____ Birth Date: _____

Home Phone: _____ Job: _____ Work Location:_____

Department:_____ Supervisor: _____ Last day worked: _____

Have you explained to your M.D. or D.O. all of the physical requirements of your job? ____**Yes** ____**No**

This is a work-related illness/injury. ____**Yes** ____**No**

MEDICAL LEAVE COVERED UNDER FAMILY/MEDICAL LEAVE ACT

I authorize release of requested information to Canadian National, Medical Services and their Medical Consultant.

_____ _____

Employee signature *Date*

M.D. or D.O. INFORMATION

*In order to **safely** place the employee to work, please provide the following pertinent information. **EVERY QUESTION MUST BE ANSWERED.***

1. Have you discussed with the employee and understand the physical demands of his/her job? ____**Yes** ____**No**
   (if no, please call Medical Services to request a copy of his/her essential physical job requirements prior to returning an employee to work with or without restrictions)
2. Current diagnosis: _____ Dates of treatment _____
3. Current treatment plan: _____ **BP** _____/_____
4. Expected prognosis - length of time for current impairments: _____
5. Medications:

Name	_____	_____	_____
Dose/frequency	_____	_____	_____
Duration	_____	_____	_____
Purpose	_____	_____	_____

6. In your judgment, will the medical condition, treatment, or medication(s) affect alertness, coordination, or thinking reactions in regards to safety? ___**Yes** ___**No**
7. After consideration of this medical condition and treatment (including medication(s), this employee can **safely** perform activities such as:

	Yes	**No**
Driving a motor vehicle	___	___
Climbing to heights on ladder	___	___
Climbing stairs/steps	___	___
Lifting/carrying (if restricted, designate weight limit: _____lbs)	___	___
Operating heavy machinery/equipment (i.e. cranes, fork lifts, locomotive engines)	___	___
Operating tools (i.e. electric drills, grinders, electric saws)	___	___
Overhead reaching/lifting	___	___
Squatting/crouching	___	___

   Other: _____

8. Employee may return to:

	Yes	**No**	**Effective date**	
Regular/Unrestricted work:	___	___	_____	
Restricted work:	___	___	_____	Specify restriction: _____
				Expected Duration of Restriction: _____

9. **Next appointment**: _____
10. Discharged/no further appointments: _____

_____ _____ _____

M.D. or D.O. (Name, please print) *(M.D. or D.O. Signature)* *Date*

_____ _____

Address *Telephone*

Fax form to: 708/332-4349

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