PHYSICIANS WORKERS' STATUS REPORT
For Employees of The State of Connecticut
PER-WC-208 REV. 10/08

State of Connecticut
Department of Administrative Services
Workers' Compensation Division

INSTRUCTIONS

1. To be completed by initial care or attending physician and provided to the injured worker as part of the office visit.
2. Mail or fax copy to State of Connecticut Third Party Claim Administration Company within 24 hours of the office visit.

- GAB Robins North America, Inc., 800 Connecticut Boulevard, East Hartford, Connecticut 06108
  Fax: (860) 291-9875
  Phone: (860) 256-3400

To be Completed By Initial Care Physician or Attending Physician

Employee Name | Social Security Number | State Agency

Division | Facility | Address

Date of Office Visit: _____/_____/_____ Date of Injury: _____/_____/_____ (Circle) Initial Visit ☐ Follow-Up Visit ☐

Diagnosis: _____

Treatment Plan: _____

Evidence of pre-existing condition: Yes ☐ No ☐ Injury/Illness casually related to worker's employment: Yes ☐ No ☐

Patient work disposition (Please check the appropriate work disposition)

1. _____ Patient is capable of full and regular duty.
2. _____ Patient is not capable of any form of work.
3. _____ Patient is capable of modified/restricted work as indicated below

Note: In terms of a normal work day; Occasionally = Up to 33%, Frequently = Up to 66%, and Continuously = Up to 100%

	Never	Occ.	Freq.	Cont.	No Restrictions
a. Patient is able to:					
Bend	_____		_____	_____	_____
Squat			_____		
Kneel			_____		_____
Stand	_____	_____	_____	_____	_____
Walk	_____		_____	_____	
Climb Stairs	_____	_____	_____	_____	_____
Twist	_____	_____	_____	_____	_____
Rotate	_____	_____	_____		_____
Push/Pull	_____	_____	_____	_____	_____
Lift above shoulder		_____	_____	_____	_____
Reach above shoulder	_____	_____	_____	_____	_____

	Never	Occ.	Freq.	Cont.	No Restrictions
b. Patient is able to lift					
Up to 10lbs	_____	_____	_____	_____	_____
11-24lbs	_____	_____	_____	_____	_____
25-34lbs	_____	_____	_____	_____	_____
35-50lbs	_____	_____	_____	_____	_____
51-74lbs	_____	_____	_____	_____	_____
75-100lbs	_____	_____	_____	_____	_____

	Never	Occ.	Freq.	Cont.	No Restrictions
c. Patient is able to carry					
Up to 10lbs	_____	_____	_____	_____	_____
11-24lbs	_____	_____	_____	_____	_____
25-34lbs	_____	_____	_____	_____	_____
35-50lbs	_____	_____	_____	_____	_____
51-74lbs	_____	_____	_____	_____	_____
75-100lbs	_____	_____	_____	_____	_____

	Never	Occ.	Freq.	Cont.	No Restrictions
d. Patient is able to use hands					
Keyboard Typing	_____	_____	_____	_____	_____
Grasping	_____	_____	_____	_____	_____

e. Is patient involved with treatment and/or medication that might affect his/her ability to work?

☐ No

☐ Yes: Explanation: _____

f. Will patient be required to use any assistive devices or braces while working regular or modified/restricted duty?

☐ No

☐ Yes: Explanation:_____

Physician Comments: _____

_____

_____

The restrictions are in effect until: _____/_____/_____Next appointment Date: _____/_____/_____

Name of Physician: _____Signature:_____

Please Print

ARRIVED:_____
DEPARTED:_____
TRAVEL:_____

Authorization to Release Information

I hereby authorize this Medical Provider to release my information acquired in the course of my examination or treatment for the above injury to my employer or it's representative.

_____ _____ _____

Patient's Name (Print) **Patient's Signature** **Date**