



Workers Compensation
<input type="checkbox"/> Yes <input type="checkbox"/> No

Duty Status Form
City of Ocala Employees

Employee Name: _____ Department: _____

Please Do Not Mark Below This Line - For Physician's Use ONLY

_____ Employee meets the medical standards required for full duty in their position (see attached job description) with **no** restrictions and **may return to work** on this date: _____.

_____ Employee is **unable to work** from _____ to _____.

_____ Employee may return to work on _____ with the **following restrictions:**

- _____ No use of injured extremity
- _____ No lifting, pushing or pulling using (___ Right ___ Left ___ or ___ Both Extremities)
Greater Than: ___ 0 lbs ___ 5 lbs ___ 10lbs ___ 15 lbs ___ 20lbs ___ 30lbs ___ 40 lbs ___ 50 lbs
___ above 50 lbs
- _____ Avoid repetitive movement of injured part
- _____ No reaching above shoulders
- _____ No prolonged standing or walking
- _____ Use splint/sling/brace during work
- _____ No use of vibratory equipment
- _____ No sweeping/mopping/shoveling
- _____ No driving (Manual ___ Automatic ___ Both ___)
- _____ Sit or stand as tolerated
- _____ May walk with breaks every ___ hour(s)
- _____ Minimal walking
- _____ No twisting or bending at the waist
- _____ No squatting, kneeling or crawling
- _____ No climbing
- _____ No use of safety sensitive equipment
- _____ Other specific restrictions _____

_____ Yes _____ No Patient has been prescribed medication that would prohibit them from driving a vehicle, operating heavy equipment or performing in any safety sensitive position.

Physician Signature: _____ Date _____

Employee Signature: _____ Date: _____

Doctor's office stamp here