CITY OF LOS ANGELES
CALIFORNIA

ERIC GARCETTI
MAYOR

INJURY STATUS REPORT

INSTRUCTIONS

EMPLOYEE RESPONSIBILITIES:

1. Provide this Injury Status Report form to your treating doctor (physician) each time you are treated for industrial or non-industrial injuries.
2. Obtain specific work restrictions from your physician.
3. Provide this completed form to your supervisor immediately after the physician evaluates you and places you off duty or determines that you may return to work.
4. Comply with the physician's restrictions or prescribed treatment (i.e., physical therapy) and avoid activities that may re-aggravate your injury.

PHYSICIAN'S RESPONSIBILITY:

1. Complete this form for all City of Los Angeles employees who you treat for industrial or non-industrial injuries and give it to the employee each time you evaluate, place off duty, impose temporary work restrictions, or return the employee to full duty.
2. Please be clear and specific when documenting restrictions. As a large and diverse employer, the City may be able to temporarily accommodate the employee's restrictions in their current job or in a temporary assignment performing activities outside their normally assigned duties. The employee may be unaware of available accommodations. The restrictions you provide will enable the City to properly accommodate the employee and protect the employee from further injury.

CITY OF LOS ANGELES
INJURY STATUS REPORT

THIS FORM MUST BE USED TO REPORT INJURY STATUS FOR EMPLOYEES OF THE CITY OF LOS ANGELES

To the Physician: *The City of Los Angeles requires that temporarily disabled employees be provided with clear and specific work restrictions. As a large and diverse employer, the City may be able to temporarily accommodate the employee's restrictions in their current job or performing duties outside their regular assignments. The employee may be unaware of available accommodations. The restrictions you provide will enable the City to properly accommodate the employee and protect the employee from further injury.*

PATIENT NAME: $claimant_name$ **INJURY DATE:** $incident_date$ **CLAIM#:** $claim_number$

BASED ON MY EVALUATION, THE PATIENT'S STATUS IS (*Check One Box*):

☐ **RETURN TO FULL UNRESTRICTED DUTY ON: _____**

☐ **TEMPORARILY PARTIALLY DISABLED from _____ thru _____**
Specify Restrictions Below.
Date of Next Appointment: _____ Estimated Return to Full Duty: _____

☐ **TEMPORARY TOTALLY DISABLED from _____ thru _____**
Specify Restrictions Below
Date of Next Appointment: _____ Estimated Return to Full Duty: _____

RESTRICTIONS: *Patient is limited to performing the following activities (indicate hours or pounds allowed per day and additional information necessary to provide clear restrictions).*

Sitting	____	hrs. allowed	_____	**Pulling/Pushing**	____	lbs. allowed	_____
Standing	____	hrs. allowed	_____	**Bending/Stopping**	____	hrs. allowed	_____
Walking	____	hrs. allowed	_____	**Reaching above**			
Bending	____	hrs. allowed	_____	**Reaching below**			
Squatting	____	hrs. allowed	_____	**Repetitive motion**	____	hrs. allowed	_____
Climbing	____	hrs. allowed	_____	**Body Part(s)**	_____		(indicate body part)
Kneeling	____	hrs. allowed	_____	**Activity**	_____		(indicate body part)
Crawling	____	hrs. allowed	_____	**Driving**	____	hrs. allowed	_____
Twisting	____	hrs. allowed	_____	**Working**	____	hrs. allowed	_____
Lifting	____	lbs. allowed	_____				
Carrying	____	lbs. allowed	_____				

Psychological (explain specific restrictions below)

Other Restrictions or Additional Information:

YOU MAY BE CONTACTED BY CITY MEDICAL STAFF TO VERIFY INJURY STATUS

I declare under penalty of perjury that this report is true and correct to the best of my knowledge.

Examining Physician (Print Name): _____ Telephone: _____

Examining Physician (Sign Name): _____ Date: _____