# Employee Work Status Report

Name: ______________________ Date: ______________________

Date of illness / injury: ______________________ DOB: ______________________

Please describe the medical facts that affect the employee's ability to work: ______________________

______________________________________________

The following medical information will apply until the next evaluation appointment on ______________________
(Date)

☐ **Regular work** as of ______________________

☐ **Can work with the following medical restrictions as of** ______________________

| | Not At All | Occasionally | Frequently | Continuously |
|---|---|---|---|---|
| ☐ Lifting ____ lbs. Max | ☐ | ☐ | ☐ | ☐ |
| ☐ Pushing / Pulling ____ lbs. Max | ☐ | ☐ | ☐ | ☐ |
| ☐ Climbing Stairs / Ladders | ☐ | ☐ | ☐ | ☐ |
| ☐ Over The Shoulder Work | ☐ | ☐ | ☐ | ☐ |
| ☐ Use Of Right Arm / Left Arm | ☐ | ☐ | ☐ | ☐ |

☐ Standing / Walking ___ hrs. with break every ___________

☐ Sitting Job Only

☐ Bending, Stooping, Twisting ☐ Not At All ☐ As Tolerated

Hands Used For Repetitive Actions

☐ Right Hand ☐ Left Hand

| | Not At All | Occasionally | Frequently | Continuously |
|---|---|---|---|---|
| A. Simple / Light Grasping | ☐ | ☐ | ☐ | ☐ |
| B. Firm Strong Grasping | ☐ | ☐ | ☐ | ☐ |
| C. Fine Dexterity | ☐ | ☐ | ☐ | ☐ |

Use: ☐ Splint ☐ Sling
☐ Crutches ☐ Comfortable Shoes ☐ Ace Wrap

☐ Driving to and from work only

☐ No driving (vehicle or equipment / machinery)

☐ Other ______________________

☐ **Incapacitated** from ______________________ to ______________________ .
(Date) (Date)

☐ **Physical Therapy** ______________________ .

Comments: ______________________

**Sign Here✈** ______________________ ______________
(Examining Physician Signature) (Date)

Physician Name: ______________________ Phone: ______________________

Physician Address: ______________________ Fax: ______________________

______________________

■ Workers' Comp
☐ Benefits

**Return to:**

**Airborne Express**
Attn: **Human Resources, 2061-B**
**145 Hunter Drive**
**Wilmington, OH 45177**
Phone: **(937) 382-5591**
Fax: **(937) 382-3056**

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# Employee Work Status Report

Name: ______________________________ Date: ______________________

Date of illness / injury: ______________________ SS#: ______________________

Please describe the medical facts that affect the employee's ability to work: ______________________

______________________________________________

The following medical information will apply until the next evaluation appointment on ______________________
(Date)

☐ **Regular work** as of ______________________

☐ **Can work with the following medical restrictions as of** ______________________

| | Not At All | Occasionally | Frequently | Continuously |
|---|---|---|---|---|
| ☐ Lifting ____ lbs. Max | ☐ | ☐ | ☐ | ☐ |
| ☐ Pushing / Pulling ____ lbs. Max | ☐ | ☐ | ☐ | ☐ |
| ☐ Climbing Stairs / Ladders | ☐ | ☐ | ☐ | ☐ |
| ☐ Over The Shoulder Work | ☐ | ☐ | ☐ | ☐ |
| ☐ Use Of Right Arm / Left Arm | ☐ | ☐ | ☐ | ☐ |

☐ Standing / Walking ___ hrs. with break every __________

☐ Sitting Job Only

☐ Bending, Stooping, Twisting ☐ Not At All ☐ As Tolerated

Hands Used For Repetitive Actions

☐ Right Hand ☐ Left Hand

| | Not At All | Occasionally | Frequently | Continuously |
|---|---|---|---|---|
| A. Simple / Light Grasping | ☐ | ☐ | ☐ | ☐ |
| B. Firm Strong Grasping | ☐ | ☐ | ☐ | ☐ |
| C. Fine Dexterity | ☐ | ☐ | ☐ | ☐ |

Use: ☐ Splint ☐ Sling

☐ Crutches ☐ Comfortable Shoes ☐ Ace Wrap

☐ Driving to and from work only

☐ No driving (vehicle or equipment / machinery)

☐ Other ______________________

☐ **Incapacitated** from ______________________ to ______________________ .
(Date) (Date)

☐ **Physical Therapy** ______________________ .

☐ **Functional Capacity Evaluation** and **On-Site Work Reconditioning**
(Lifting restrictions must be removed for the purpose of evaluation and rehabilitation.)

Comments: ______________________________________________

**Sign Here✈** ______________________ ______________
(Examining Physician Signature) (Date)

Physician Name: ______________________ Phone: ______________________

Physician Address: ______________________ Fax: ______________________

______________________

☐ Workers' Comp
■ Benefits

**Return to:** **ABX Air, Inc.**
Attn: **Human Resources, 2061-B**
**145 Hunter Drive**
**Wilmington, OH 45177**
Phone: **(937) 382-5591**
Fax: **(937) 382-3056**