UTMB Occupational Medicine Clinic

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Injury Status Report

Date: ______/______/______

Time In: ____________ AM PM

Claim #: ____________

Name: ____________

Company: ____________

Occupation: ____________

Dept: ____________

DOI: ______/______/______

LDW: ______/______/______

Diagnosis: ____________

Treatment: ____________

Medications: ____________

Referrals: ____________

Disposition:

[ ] Return to Full Duty

[ ] Return to Modified Duty

[ ] Off work until ______/______/______

[ ] Next appt: ______/______/______ @ ______ AM PM

Restrictions: ____________

Comments: ____________

Time Out: ____________ AM PM

Treating Physician: ____________

Date: ______/______/______

Employee Signature: ____________

Date: ______/______/______