MEDICAL EVALUATION OF WORK STATUS FORM
Occupational Medical Service, NIH

Patient's Name _____ Patient's SSN _____
Last 4 digits

Diagnosis(es) _____

☐ Functional restrictions are not recommended

☐ The following functional restrictions are recommended: (Check all that apply)

☐ No climbing stairs or ladders	☐ No twisting or bending
☐ No stooping or kneeling	☐ No standing longer than ____ min per hour
☐ No reaching above shoulder	☐ No walking longer than ____ min per hour
☐ No reaching below knee	☐ No sitting longer than ____ min per hour
☐ No use of arm: ☐Left ☐Right	☐ No lifting or carrying > ____ pounds
☐ No use of hand: ☐Left ☐Right	☐ No pulling or pushing > ____ pounds
☐ No fine manipulation	☐ No operating motor vehicle
☐ Wear splint while working	☐ Other, please describe:

The functional restrictions are needed from _____ through _____.
Month/Day/Year Month/Day/Year

Date of next appointment _____
Month/Day/Year

_____
Health Care Practitioner's Name (Printed) Title (e.g. MD, PA, NP)

_____
Health Care Practitioner's Signature Date (Month/Day/Year)

Please contact the following OMS clinician_____ if you have questions at:

Bethesda, MD	Phone: 301-496-4411	Fax: 301-402-0673
Frederick, MD	Phone: 301-631-7233	Fax: 301-631-7391
Baltimore, MD	Phone: 443-740-2309	Fax: 443-740-2081
Hamilton, MT	Phone: 406-375-9755	Fax: 406-375-9279

This form needs to be completed by your personal health care practitioner and returned to OMS.