The Oregon Department of Corrections provides a transitional work program for short-term, medically restricted employees who have experienced injury or illness on or off the job. This transitional work program is designed to provide transitional work as approved by the treating physician and as appropriate for the employee’s temporary physical limitations and/or restrictions. Transitional work is normally limited to 30 days with possible extensions after review, but at no time shall transitional work extend beyond 90 days. The employee is expected to adhere to the treating physician’s restrictions. The supervisor monitors for compliance with the transitional work program.


1. Employee Information:
   Name: ________________________________ Date of Injury/illness: __________

2. Return to Work Status:
   PLEASE CHECK APPROPRIATE STATUS (ONE ONLY):
   _____ May return to regular job (complete items 5 - 8) Date: __________
   _____ May return to transitional/modified duty (complete items 1 – 8) Date: __________
   _____ May not return to any work (complete items 5 - 8)

   Estimated date of return: ______________________

3. Temporary Physical Limitations: (No comment indicates no limitation)
   C = Continuous, no limit, 66% to 100% of the day
   F = Frequently, 34%-65% of the day
   O = Occasionally, up to 33% of the day
   N = Not OK

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>C</th>
<th>F</th>
<th>O</th>
<th>N</th>
<th>Lifting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0-10 lbs.</td>
</tr>
<tr>
<td>Squat</td>
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<td></td>
<td></td>
<td></td>
<td>11-20 lbs.</td>
</tr>
<tr>
<td>Crawl</td>
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<td></td>
<td>21-40 lbs.</td>
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<tr>
<td>Twist</td>
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<td></td>
<td></td>
<td></td>
<td>41-60 lbs.</td>
</tr>
<tr>
<td>Reach above shoulders</td>
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<td></td>
<td></td>
<td></td>
<td>Over 60 lbs.</td>
</tr>
<tr>
<td>Walk ramps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use arms/repeated pushing/pulling</td>
</tr>
<tr>
<td>Use stairs/steps/step-stools</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use arms/repeated grasp/lift/carry</td>
</tr>
<tr>
<td>Use ladders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use hands/repeated fine manipulations</td>
</tr>
<tr>
<td>Run/Walk on rough/uneven surfaces</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Carry: (max. lbs. Ok?)</td>
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<tr>
<td>Run or jog up to 200 yards</td>
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<tr>
<td>Push or pull loads up to 175 lbs.</td>
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<tr>
<td>Pull, drag, or carry loads with an average weight of 162 lbs. for a distance up to 40 yards</td>
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<tr>
<td>Operate a motor vehicle</td>
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</tbody>
</table>
Please be aware that "no inmate contact" is not a statement of physical limitation. Providing an accurate assessment of physical limitations permits us to determine a safe work assignment for the employee. A "no inmate contact" limitation prohibits the employee from working anywhere in the institution or possibly on any DOC grounds. There is potential for inmate contact within an institution going to and from restrooms, staff dining rooms, or locker rooms. There may also be incidental contact with inmate orderlies at any DOC facility.

4. Endurance:

Please indicate below the number of hours these activities should be limited to.

<table>
<thead>
<tr>
<th>Hours</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Standing</td>
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<td></td>
</tr>
<tr>
<td>Walking</td>
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<td></td>
</tr>
</tbody>
</table>

Total number of hour's patient may work per day: ___________________________ Per Week: ___________________________

5. Medically Stationary Yes ____ No ____: Permanent Physical Restrictions (list):

6. Physician’s Comments or Suggestions: ___________________________

   ___________________________

   ___________________________

   ___________________________

7. Date of Next Appointment: ___________________________

8. Physician’s Signature: ___________________________ Date: __________

   Address: ___________________________ Phone: ___________________________

The information on this form will be kept confidential, except that supervisors and managers may be informed regarding restrictions on the work or duties of employees. Agency medical consultants and safety personnel may be informed, where appropriate, if a condition requires emergency treatment. Government officials investigating compliance with the law shall be provided relevant information upon request.

Employee Medical Release Authorization

I HEREBY AUTHORIZE the addressee below to release the medical information requested on this form, which is relevant to work capacity and/or performance. I EXPECT THIS INFORMATION TO BE TREATED IN THE STRICTEST OF CONFIDENCE and used only to determine what temporary or permanent modifications may be made for my work assignment.

Employees Signature: ___________________________ Date: __________

Physician Addressee: ___________________________ Phone Number: ___________________________

Address: ___________________________ Street or PO Box ___________________________ City ___________________________ State ___________________________ Zip