

## Work Status Report

### Patient/Member Information

|                                                                                               |             |                                       |                                 |
|-----------------------------------------------------------------------------------------------|-------------|---------------------------------------|---------------------------------|
| Name (printed)                                                                                |             |                                       |                                 |
| Birth date                                                                                    | Injury date | <input type="checkbox"/> Fire         | <input type="checkbox"/> Police |
| Body part(s) injured                                                                          |             | Claim number                          |                                 |
| Loss time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No As of what date |             | Has time off been reported to bureau? |                                 |

### Physician/Medical Provider Information

|                                                                                                  |                                             |                      |
|--------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------|
| <input type="checkbox"/> Member is unable to perform any work                                    | From (date) _____                           | Through (date) _____ |
| <input type="checkbox"/> The Member is released to Light Duty                                    | From (date) _____                           | Through (date) _____ |
| <i>(If longer than 30-days attach report to explain needed time off. No longer than 60 days)</i> |                                             |                      |
| Member is to follow up in _____ days / weeks (circle one)                                        | The Member has Permanent Restrictions as of |                      |
| Next Appointment Date (if known) _____                                                           | (date) _____ (attach chart note/ report)    |                      |

### Current Restrictions/Physical Capabilities

|                                                                                  |                                                          |                                   |                                   |                                   |                                |                               |                              |                               |                                |                               |
|----------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|--------------------------------|-------------------------------|------------------------------|-------------------------------|--------------------------------|-------------------------------|
| Select one:                                                                      | <input type="checkbox"/> Limited use                     | <input type="checkbox"/> No use   | <input type="checkbox"/> Right    | <input type="checkbox"/> Left     |                                |                               |                              |                               |                                |                               |
| Check all that apply:                                                            |                                                          |                                   |                                   |                                   |                                |                               |                              |                               |                                |                               |
| <input type="checkbox"/> Back                                                    | <input type="checkbox"/> Neck                            | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Arm      | <input type="checkbox"/> Elbow    | <input type="checkbox"/> Wrist | <input type="checkbox"/> Hand | <input type="checkbox"/> Leg | <input type="checkbox"/> Knee | <input type="checkbox"/> Ankle | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Max lifting _____ lbs.                                  | <input type="checkbox"/> Overhead                        | <input type="checkbox"/> Reaching | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Pulling  |                                |                               |                              |                               |                                |                               |
| <input type="checkbox"/> Avoid forceful repetitive gripping                      | <input type="checkbox"/> Climbing                        | <input type="checkbox"/> Stooping | <input type="checkbox"/> Walking  | <input type="checkbox"/> Pushing  |                                |                               |                              |                               |                                |                               |
| <input type="checkbox"/> Alternate sitting/standing                              | <input type="checkbox"/> Squatting                       | <input type="checkbox"/> Bending  | <input type="checkbox"/> Twisting | <input type="checkbox"/> Standing |                                |                               |                              |                               |                                |                               |
| <input type="checkbox"/> Can wear vest/gun belt                                  |                                                          |                                   |                                   |                                   |                                |                               |                              |                               |                                |                               |
| <input type="checkbox"/> Allowed to drive                                        |                                                          |                                   |                                   |                                   |                                |                               |                              |                               |                                |                               |
| <input type="checkbox"/> Restricted to _____ hours of transitional duty per day. | Police Only: Can officer attend court?                   |                                   | <input type="checkbox"/> Yes      | <input type="checkbox"/> No       |                                |                               |                              |                               |                                |                               |
| Member is released to full duty (without restrictions)                           | Medically stationary? <input type="checkbox"/> Yes, date |                                   |                                   |                                   |                                |                               |                              |                               |                                |                               |
| Date released                                                                    | <input type="checkbox"/> No, anticipated date            |                                   |                                   |                                   |                                |                               |                              |                               |                                |                               |
| Physician name (Print name with professional designation MD, DO, DPM, DC, other) |                                                          |                                   |                                   |                                   |                                |                               |                              |                               |                                |                               |
| Physician signature                                                              |                                                          |                                   | Date                              |                                   |                                |                               |                              |                               |                                |                               |
| Physician/Provider address                                                       |                                                          |                                   |                                   |                                   |                                |                               |                              |                               |                                |                               |
| Physician/Provider phone                                                         |                                                          |                                   | Physician/Provider fax            |                                   |                                |                               |                              |                               |                                |                               |

On duty supervisor \_\_\_\_\_ RU Commander/Battalion or Bureau Chief \_\_\_\_\_

**Supervisor/Bureau: Obtain needed signatures and return original to FPDR.**

Information for Member and Health Care Providers on back



## Work Status Report

### Instructions for Member and Health Care Providers

#### Member Instructions

The Bureau of Fire and Police Disability and Retirement (FPDR) is sorry to hear of your injury. The FPDR Work Status Report (WSR) form is required to document your inability to work and/or physical restrictions and limitations following an injury and throughout your recovery. While we ask your provider to assist in submitting the WSR to FPDR it is ultimately your responsibility to ensure that FPDR has received this form as soon as possible following your injury and throughout your recovery. We must have this form prior to paying disability benefits.

- 1 Complete the Patient/Member information section of this form in its entirety.
- 2 Give the form to your doctor, urgent care or emergency department doctor/provider for completion of their portion of the form.
- 3 Ask the doctor to complete their portion of the form and fax the form to FPDR at 503-823-5166.
- 4 Keep a copy of the completed form for your record. Fax a copy of the form to FPDR to ensure receipt.
- 5 Please call FPDR if you have any questions or concerns about this form or its submission to FPDR.

#### Provider Instructions

- 1 Please complete the Physician/Medical Provider Information in its entirety.
- 2 Sign and date the Work Status Report (WSR) form.
- 3 Fax the WSR to FPDR at 503-823-5166 or email the form to [fpdr@portlandoregon.gov](mailto:fpdr@portlandoregon.gov)
- 4 Give a copy of the form to the member for their record.

#### About the FPDR Transitional Duty Return to Work Program

The Bureau of Fire and Police Disability and Retirement (FPDR), as established in Chapter 5 of the Charter of the City of Portland, Oregon is a workers' compensation type of a plan, not a health plan. The City of Portland's sworn firefighters and police officers **are exempt** from coverage by the Oregon Workers' Compensation system, but FPDR is a disability system similar to it.

The FPDR prescribes to the concept of "work as therapy" following an injury. To that end, the FPDR has a **Transitional Duty Return to Work Program** that reimburses the employer for wages paid to our members when they provide transitional light duty work for our members while they recover from injury.

**The member's employing bureaus have a variety of light duty positions available to our members.**

Upon receipt of the Work Status Report (WSR) documenting the members' restrictions, FPDR and the bureaus of Fire and Police will work to place the member in a Transitional Duty position.

**Here are a few of the benefits of transitional light duty employment for our members:**

- Financial stability. Members are paid a full wage while in the transitional duty program.
- Maintain connected to peers and employer.
- Mobility while prepping to get to work and while performing light duty work.
- Employing bureau utilizes highly skilled professionals to do important work.

**Please complete the WSR and return it to FPDR at the earliest opportunity.**

