Appendix 11: Worker's Progress Report Form

Employee's Name: _____ **Date:** _____ **Date of Injury:** _____

Claim Number: _____ **Report Period: From:** _____**To:** _____

Treating Physician: _____ **Phone #:** _____ **Fax #:** _____

(Please check the appropriate statement)

☐ The job duties which I have been performing for the past _____ week(s) have been within my physical restrictions/ limitations, which were prescribed by my treating physician/ health care specialist. I have not encountered any difficulties performing the assigned tasks.

☐ I am having difficulty performing the job duties (or a component of the work) which have been assigned to me, for the following reasons:

_____
_____
_____
_____
_____
_____
_____

I feel that my physical condition has:

☐ Improved ☐ Remained the same ☐ Deteriorated

Please explain any concerns that you may have regarding your return to work.

_____
_____
_____
_____
_____

Note: Any questions, concerns, or problems must be addressed with your supervisor, in cooperation with the Modified Work Committee and/ or the Joint Health and Safety Committee.

Worker's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Reviewed By: _____ Date: _____