# Work Status Form

The University of California, Santa Barbara is committed to achieving a successful recovery and return to work for our ill/injured employees. The Transitional Work Program (TWP) is designed to help employees return to work safely and at the earliest opportunity, using appropriate modified work alternatives when needed.

<table>
<thead>
<tr>
<th>EMPLOYEE'S INFORMATION</th>
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<tbody>
<tr>
<td>Employee Name (please print)</td>
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</table>

**To be completed by PHYSICIAN/ TREATING PROVIDER:**

NO diagnostic information please

This employee may perform:

- [ ] Modified Duties from: ____________ to: ____________ with the following restrictions:
  - Keyboard ______ Minutes/ Hour
  - Sit ______ Minutes/ Hour
  - Stand/ Walk ______ Minutes/ Hour
  - Climb ______ Minutes/ Hour
  - Lift/ Carry ______ LBS Maximum
  - Push/ Pull ______ LBS Maximum

- [ ] Modified Hours from: ____________ to: ____________ with the following schedule:
  - _______ Hours per Day, _______ Days per Week - OR - _______ Hours per Week

- [ ] Not Capable of ANY Work from: ____________ to: ____________

- [ ] Full/ Regular Duty ____________

Next appointment: ____________

Comments: ____________________________________________

Treating Provider’s Name and Address or Stamp  
Treating Provider’s Signature  
Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information,’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual, an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PLEASE RETURN THE COMPLETED FORM TO YOUR SUPERVISOR AND/OR DEPARTMENT REPRESENTATIVE