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**Bureau of Fire and Police
Disability and Retirement**

1800 SW First Avenue, Suite 450,
Portland, OR 97201
503-823-6823; FAX – 503-823-5166;
B236/450

**WORK STATUS REPORT
(WSR)**



July 2014

PATIENT INFORMATION	<input type="checkbox"/> Fire <input type="checkbox"/> Police	CLAIM NUMBER:	FPDR DATE STAMP
	Member's Legal Name:	INJURY DATE:	
		BODY PART(S) INJURED:	
1	<input type="checkbox"/> Member is unable to perform any work from _____ to _____ (no longer than 3 mos.)		
2	<input type="checkbox"/> Member is released to Restricted Duty (Please complete the start and re-evaluation date) <input type="checkbox"/> Temporary Transitional Restrictions – Start Date: _____ Re-evaluation Date: _____ <input type="checkbox"/> Permanent Restrictions – Effective Date: _____ <p align="center">PLEASE COMPLETE CURRENT PHYSICAL CAPABILITIES</p> <p>Limited Use <input type="checkbox"/> or No Use <input type="checkbox"/> Right <input type="checkbox"/> and/ or Left <input type="checkbox"/></p> <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"/> Avoid forceful repetitive gripping <input type="checkbox"/> Alternate sitting/standing <input type="checkbox"/> Can wear vest/gun belt <input type="checkbox"/> Allowed to drive <input type="checkbox"/> Restricted to _____ hrs of limited duty per day		
3	<input type="checkbox"/> Member is released to FULL DUTY (without restrictions) Date Released: _____ <input type="checkbox"/> Member is medically stationary <input type="checkbox"/> Yes, as of _____ (Date) <input type="checkbox"/> No	POLICE ONLY Can Officer attend Court? Yes <input type="checkbox"/> No <input type="checkbox"/>	
4	Next Appointment Date: _____		

Attending Physician (MD, DO or DPM) PRINTED NAME

Telephone

Attending Physician (MD, DO or DPM) SIGNATURE

Date

DOCTOR: _____ FAX COPY TO FPDR, PROVIDE ORIGINAL TO MEMBER & RETAIN A COPY

MEMBER: _____ FAX COPY TO FPDR, PROVIDE TO SUPERVISOR & RETAIN COPY FOR YOUR RECORDS

SUPERVISOR: FAX WSR TO FPDR @ 503-823-5166 (check box and initial/date)

BUREAU: RETURN ORIGINAL TO FPDR (check box and initial/date)

IMPORTANT INFORMATION: WSR MUST BE SUBMITTED TO FPDR WITHIN THE PAY PERIOD THE DISABILITY IS DUE TO BE ELIGIBLE FOR A TIMELY DISABILITY PAYMENT.

C: FPDR to Bureau Liaison

Bureau Signatures:

On Duty Supervisor _____ RU Commander/Battalion Chief _____