

TRANSITIONAL EMPLOYMENT PROGRESS REPORT

Transitional Work Status

To: Dr. _____	Date of Injury: _____
Re: Employee Name: _____	Reporting period: _____ to _____
Company Name: _____	Work Return Date: _____

Check one which applies:

- 1. Regular job
- 2. Temporary modified/alternative job
- 3. Participation in rehabilitation in conjunction with restricted job duties
- 4. Participation in Rehabilitation and not currently working
- 5. Not currently working
- 6. Other specify _____

Work Schedule:

Timeframe of Shift _____
Number of hours worked in week _____
Available breaks _____

Was employee off work during reporting period? Yes _____ No _____

Length off work _____
Length of Transitional Employment Program _____

Progress/Functional Status

Any specific activities that cause discomfort or pain? Specify: _____

Identify improvements/tolerance. Describe: _____

Has performance of job activities gradually increased? _____

Barriers: _____

Employee Concerns/Questions: _____

Employer Concerns /Questions: _____

Employee: _____ Date: _____ Employer Representative: _____ Date: _____

**Please bring copy of progress report to next medical appointment. Or Fax to: Occupational Medicine 217-383-3519
Attention: Case Coordinators**