ATTACHMENT I
MS 682
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U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs (OWCP)

DUTY STATUS REPORT

JAN 31 1983

PART A - SUPERVISOR

1. NAME AND ADDRESS *(Last, first, middle)*
Arthur Evans, M.D.
Riverside Hospital
Washington, D.C. 20007

2. EMPLOYEE'S NAME (*Last, first, middle)*	3. DATE OF INJURY *(Mo., day, year)*	4. OCCUPATION	5. SOCIAL SECURITY NUMBER
DOE, JOHN HENRY	11/4/80	Country Desk Officer	000-00-000

6. DESCRIBE HOW THE INJURY OCCURRED AND PARTS OF THE BODY AFFECTED.
Automobile Accident, sustaining an injury to his back

7. DESCRIPTION OF REGULAR WORK INCLUDING PHYSICAL REQUIREMENTS N/A

a. EXPOSURE *(Check applicable exposure and fill in number of hours of exposure each work day.)*
HEAT _____ COLD _____ NOISE _____ DUST _____

FUMES _____ STRESS _____ OTHER _____

b. PHYSICAL REQUIREMENTS OF REGULAR WORK

Frequency (*Provide frequency, i.e., number of times or hours per day, in appropriate box.)*

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY - LIFT 0 TO 10 POUNDS			
LIGHT - LIFTING 10 TO 20 POUNDS			
MODERATE - LIFTING 20 TO 50 POUNDS			
HEAVY - LIFTING 50 TO 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
Otther:			

8. SEND A COPY OF THIS REPORT TO:
Jim Frison
U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Program
Washington, D.C. 20211

9. NAME AND ADDRESS OF EMPLOYING AGENCY, WHICH IS TO RECEIVE THE ORIGINAL REPORT.
Peace Corps
Office of Medical Services
806 Connecticut Avenue, N.W.
Washington, D.C. 20526

INSTRUCTIONS FOR COMPLETION AND SUBMISSION OF DUTY STATUS REPORT

SUPERVISOR: Complete Part A. The form should then be referred to the attending physician for completion of Part B.

ATTENDING PHYSICIAN: Complete Part B. The original form should be returned to the employing agency (as shown in item 9). To prevent interruption in the continuation of the employee's pay, the completed form should be returned to the employing agency within two days following examination and/or treatment. A copy of the form should also be sent to OWCP (as shown in item 8).

Form CA-17
Rev. July 1979

PART B - PHYSICIAN

10. IS THE EMPLOYEE ABLE TO PERFORM HIS/HER REGULAR WORK *(Described in item 7)?* [ ] YES [ ] NO JAN 31, 1983
(if yes, indicate whether part or full-time and date able to resume such work.)

[ ] PART TIME [ ] FULL TIME *Date (Mo., day, year)*
Hours a day

11. IS THE EMPLOYEE ABLE TO PERFORM LIGHT WORK? [ ] NO [ ] YES. IF YES, CHECK THE WORK TOLERANCE LIMITATIONS WHICH ARE DUE TO THE INJURY. *(Including Preexisting Conditions.)*

	LITTLE OR NONE	MODERATE	OFTEN
SEDENTARY - LIFT 0 TO 10 POUNDS			
LIGHT - LIFTING 10 TO 20 POUNDS			
MODERATE - LIFTING 20 TO 50 POUNDS			
HEAVY - LIFTING 50 TO 100 POUNDS			
PULLING/PUSHING, CARRYING			
REACHING OR WORKING ABOVE SHOULDER			
WALKING (HOURS)			
STANDING (HOURS)			
SITTING (HOURS)			
STOOPING (HOURS)			
KNEELING (HOURS)			
REPEATED BENDING (HOURS)			
CLIMBING (HOURS)			
OPERATING A MOTOR VEHICLE, CRANE, TRACTOR, ETC.			
Other:			
Exposure Limitations (*specify*):			

12. IF THE EMPLOYEE IS TOTALLY DISABLED FOR DUTY, GIVE A BRIEF REPORT AND PROGNOSIS

13. PERIOD OF DISABILITY *(if termination date unknown, so indicate)*

TOTAL DISABILITY FROM TO

PARTIAL DISABILITY FROM TO

14. DATE EMPLOYEE ABLE TO RESUME WORK *(Mo., day, year)*

LIGHT WORK [ ]

REGULAR WORK [ ]

15. IF EMPLOYEE IS ABLE TO RESUME WORK, HAS HE/SHE BEEN ADVISED? [ ] YES [ ] NO. IF YES, FURNISH DATE ADVISED *(Mo, day, year)*

16. DIAGNOSIS OF CONDITION DUE TO INJURY

17. DATE OF EXAMINATION

19. DATES OF FURTHER APPOINTMENTS, IF ANY

19. SIGNATURE AND TYPED OR PRINTED NAME OF PHYSICIAN

20. PROFESSIONAL DEGREE

21. DATE *(Mo., day, year)*

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