



Work Capabilities

Name _____

Employer _____

Date of Injury _____

Diagnosis _____

Recommendation for Work:

Prognosis: _____

- Not disabled-may return to work at normal capacity
 Transitional Duty as of: _____ (See below)
 Full Duty as of: _____

Activity	May Perform		Comments: time limitation, left/right, etc.
	Yes	No	
Lift/ Carry			<input type="checkbox"/> 0-5# <input type="checkbox"/> 5-10# <input type="checkbox"/> 11-25# <input type="checkbox"/> 26-50# <input type="checkbox"/> 51-100#
Push/Pull			<input type="checkbox"/> 0-25# <input type="checkbox"/> 26-50# <input type="checkbox"/> 51-75# <input type="checkbox"/> 76-100# <input type="checkbox"/> Only on wheels
Sitting			
Standing			_____ minutes/hour or _____ hours/day
Walking			_____ minutes/hour or _____ hours/day
Bending			Limited to _____ degrees at waist
Twisting/rotation			
Grasping/Gripping			
Fine manipulation (hands)			
Crimping			
Repetitive wrist use			
Kneeling/Squatting			
Use of Vibrating Tools			
Reaching/Overhead Work			
Climbing ladder/stairs			
Use of feet (foot controls)			
Visual			<input type="checkbox"/> No tasks requiring binocular vision
Hearing			
Driving			<input type="checkbox"/> Manual <input type="checkbox"/> Automatic
Other			

- Alternate standing and sitting frequently
 Sitting job only
 No use of right / left _____
 Must wear brace/splint at work
 Must keep _____ elevated
 May not operate a motor vehicle/forklift/machinery
 Taking medications during the workday that may cause drowsiness (alternative options unavailable)
 → Caution driving, working at heights, working with machinery/tools that are sharp or otherwise require mental alertness or muscular coordination. Employee understands that he/she is responsible for getting to work safely.

Provider _____

Signature _____ Date _____

Date of next appointment with provider: _____