

Date of Injury: \_\_\_\_\_

### Work Capabilities Form

Form recommended for use by medical providers in assessing work capabilities of patients with work injuries

Employee's Name: \_\_\_\_\_ Based on my examination of this patient on: \_\_\_\_/\_\_\_\_/\_\_\_\_

- May **NOT RETURN TO WORK** Estimated duration of total disability: \_\_\_\_\_
- May **Return to Work with NO RESTRICTIONS**
- May **Return to Work on** \_\_\_\_\_ with the following capabilities:

**Stand/Walk:**

- Not at all       1-3 hours       3-5 hours       5-8 hours       Unrestricted

**Sit:**

- Not at all       1-3 hours       3-5 hours       5-8 hours       Unrestricted

**Drive:**

- Not at all       1-3 hours       3-5 hours       5-8 hours       Unrestricted

**Lift:**

- Not at all
- |   |                                       |                                     |
|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> No more than <b>10</b> lbs.  | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Frequently |
| <input type="checkbox"/> No more than <b>20</b> lbs.  | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Frequently |
| <input type="checkbox"/> No more than <b>50</b> lbs.  | <input type="checkbox"/> Occasionally | <input type="checkbox"/> Frequently |
| <input type="checkbox"/> No more than <b>100</b> lbs. | <input type="checkbox"/> Occasionally |                                     |
- Unrestricted

**Bend:**

- Not at all       Occasionally       Frequently       Unrestricted

**Squat:**

- Not at all       Occasionally       Frequently       Unrestricted

**Climb:**

- Not at all       Occasionally       Frequently       Unrestricted

**Twist:**

- Not at all       Occasionally       Frequently       Unrestricted

**Reach above shoulders:**

- Not at all       Occasionally       Frequently       Unrestricted

Specific work capabilities not listed above: \_\_\_\_\_

Employee has limited use of: \_\_\_\_\_

Employee  can  cannot perform repetitive activities for more than \_\_\_\_\_ min/hrs.

Employee  can  cannot work more than 8 hours a day.

Work capabilities are in effect until: \_\_\_\_\_ ; or  until further evaluation.

Scheduled for a follow-up appointment on: \_\_\_\_\_

Referred to: \_\_\_\_\_ for follow-up care.

\_\_\_\_\_  
Medical Provider's Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Providers Signature

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize this medical provider to release any information acquired in the course of my examination or treatment for the above injury to my employer or its representative.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

for more  
information :

