

Return to Work/Physical Capability Form

Patient _____

Physician _____

Diagnosis _____

Treatment (needed for OSHA rules and placement)

- Narcotic analgesic Anti-inflammatory medication Sutures
 Physical therapy Other _____

- Condition: Improved
 Symptoms Worse
 Unchanged
 Not Applicable

I saw this patient on (date) _____ and based on the above description of the patient's current medical problem (check all that apply):

- Return to regular duty on (date) _____
 Return to work on (date) _____ with restrictions:
 temporary permanent
 Off work until (date) _____

Patient to be reevaluated: _____ days _____ weeks.

Total hours of work per day:

- 4 hours
 6 hours
 8 hours
 10 hours
 No restriction
 Other _____

Heavy work. Lifting 50 lbs. frequently with occasional lifting and/or carrying objects weighing up to 100 lbs.

Medium-heavy work. Lifting 40 lbs. frequently with occasional lifting and/or carrying of objects weighing up to 75 lbs.

Medium work. Lifting 25 lbs. frequently with occasional lifting and/or carrying objects weighing up to 50 lbs.

Light-medium work. Lifting 20 lbs. frequently with occasional lifting and/or carrying objects weighing up to 30 lbs.

Light work. Lifting 10 lbs. frequently with occasional lifting and/or carrying objects weighing up to 20 lbs. Even though the weight lifted may be a negligible amount, this category would include a job that requires walking or standing to a significant degree or involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

Sedentary work. Lifting 10 lbs. maximum and occasionally lifting and/or carrying such articles as files, light packages and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

	Continuously 67-100%	Frequently 34-66%	Occasionally 11-33%	Seldom 1-10%	Restricted 0%
<input type="checkbox"/> Not applicable					
Sit/drive	<input type="checkbox"/>				
Stand	<input type="checkbox"/>				
Walk	<input type="checkbox"/>				
Bend	<input type="checkbox"/>				
Twist	<input type="checkbox"/>				
Climb	<input type="checkbox"/>				
Squat	<input type="checkbox"/>				
Work overhead	<input type="checkbox"/>				
Work shoulder level	<input type="checkbox"/>				

Hand: Specify—Right [R]; Left [L]; Bilateral [B]

	Continuously 67-100%	Frequently 34-66%	Occasionally 11-33%	Seldom 1-10%	Restricted 0%
<input type="checkbox"/> Not applicable					
Grasp	<input type="checkbox"/>				
Pincer grip	<input type="checkbox"/>				
Reach	<input type="checkbox"/>				
Twist (wrist)	<input type="checkbox"/>				
Push/pull w/hands	<input type="checkbox"/>				
Wrist flexion/extension	<input type="checkbox"/>				

Feet: Specify—Right [R]; Left [L]; Bilateral [B]

	Continuously 67-100%	Frequently 34-66%	Occasionally 11-33%	Seldom 1-10%	Restricted 0%
Repetitive movements as in operating foot controls	<input type="checkbox"/>				

- No exposure to moving machinery No exposure to unprotected heights
 Avoid wet work Avoid irritants (specify)

Patient referred to (physician) _____

Other instructions and/or limitations _____

Physician signature _____ Date _____ Time _____

This side to be completed by physician. Opposite side to be completed by employer. Date: _____

Employer's Physical Capacities Requirements

Employee name _____

Policyholder name _____ Policy No. _____

Department _____

Job title _____

Hours per shift _____

Date of injury _____

Basic job requirements

	Continuously 67-100%	Frequently 34-66%	Occasionally 11-33%	Seldom 1-10%	Restricted 0%
Sitting	<input type="checkbox"/>				
Standing	<input type="checkbox"/>				
Walking	<input type="checkbox"/>				

Mobility

Lifting	<input type="checkbox"/>				
Bending	<input type="checkbox"/>				
Squatting	<input type="checkbox"/>				
Reaching	<input type="checkbox"/>				
Kneeling	<input type="checkbox"/>				
Pushing	<input type="checkbox"/>				
Pulling	<input type="checkbox"/>				

Lifting

0 to 10 lbs.	<input type="checkbox"/>				
11 to 25 lbs.	<input type="checkbox"/>				
26 to 50 lbs.	<input type="checkbox"/>				
51 to 75 lbs.	<input type="checkbox"/>				
76 to 100 lbs.	<input type="checkbox"/>				
100+ lbs.	<input type="checkbox"/>				

Carrying weight

0 to 10 lbs.	<input type="checkbox"/>				
11 to 25 lbs.	<input type="checkbox"/>				
26 to 50 lbs.	<input type="checkbox"/>				
51 to 75 lbs.	<input type="checkbox"/>				
76 to 100 lbs.	<input type="checkbox"/>				
100+ lbs.	<input type="checkbox"/>				

Repetitive motion

	<i>Right hand</i>		<i>Left hand</i>	
Dexterity	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
Grasping	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
Writing	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no
Typing	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> yes	<input type="checkbox"/> no

Other physical requirements

Employer representative signature _____ Date _____

Employer/insurer contact _____