

## Physical Capabilities Worksheet

You are treating a valuable employee and we would like to assist in this patient recovery back to full health. We are able to accommodating many restrictions you find necessary to ensure the full recovery of this patient and assist in the transition to full duty employment.

We ask that you complete this form after your examination and outline all restrictions, if any, you have assigned to this patient. Please include modified hours, duties and any other information pertinent to this employee's healthy recovery.

Employee: \_\_\_\_\_ Title: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Social Security: \_\_\_\_\_

Activity	N	S	O	C	Activity	N	S	O	C
<b>Lifting/Carrying:</b>					Bend				
10 Lbs. or less					Squat				
11 – 20 Lbs.					Kneel				
21- 40 Lbs.					Twist/Turn				
40- 60 Lbs.					Climb				
61 – 100 Lbs.					Crawl				
100 + Lbs.					Stand				
Comments:					Reach Above Shoulder				
<b>Pushing/Pulling</b>	N	S	O	C	Walk				
12 Lbs. or less					Sit				
13-25 Lbs.					Type/Keyboard				
26-40 Lbs.									
41-60 Lbs.					<b>Drive:</b>				
61-100 Lbs.					Automatic				
100+ Lbs.					Standard				
Comments					Comments:				
General Comments or Additional Restrictions:									

Mark the appropriate box for each of the following activities to indicate the extent to which the employee can perform:

**Key:**

- N = Never
- S = Sometimes; 1 – 33% of time
- O = Occasional; 34-66% of time
- C = Constant; 67-100% of time

Please fax form to:

Physician Name \_\_\_\_\_

Date \_\_\_\_\_

Telephone \_\_\_\_\_

Physician's Signature \_\_\_\_\_