Instructions: This form must be completed by the physician after each medical appointment or every thirty days whichever comes first.

PHYSICIAN'S REPORT OF WORK ABILITY

Non-Work-Related Injuries

Injured Worker's Name:		**Date of Injury:**
Diagnosis::	**Date of this exam:**	**Next appointment date:**
Did you review a written description of the employee's job duties? ☐ **Yes** ☐ **No**		

Please complete the following assessment based upon your clinical findings to document the employee's ability to work.

Work Status

☐ **May return to work with no restrictions on _____.**

☐ **May return to work with temporary restrictions*: from _____ to _____.**

☐ **Temporarily unable to work from* _____ to _____.**

***Indicate estimated return to full duty: _____.**

If the employee's restrictions are long-term or permanent, the employee may be eligible for a reasonable accommodation under the Americans with Disabilities Act. Additional information may be requested.

Work/Non-Work Capabilities

	None at all	**Occasional**	**Frequent**	**Continuous**
% of 8hr workday	*0%*	*1-33%*	*34-66%*	*67-100%*
***or** repetitions per hr*		*4-6*	*6-12*	*>12*
Sit……..	☐	☐	☐	☐
Stand…….	☐	☐	☐	☐
Walk……..	☐	☐	☐	☐
Lift or carry:				
Up to 10lbs…….	☐	☐	☐	☐
11lbs to 20lbs……..	☐	☐	☐	☐
21lbs to 50lbs…….	☐	☐	☐	☐
51lbs to 100lbs……	☐	☐	☐	☐
Over 100lbs…….	☐	☐	☐	☐
Pushing/Pulling:				
Up to 10lbs…….	☐	☐	☐	☐
11lbs to 20lbs……..	☐	☐	☐	☐
21lbs to 50lbs…….	☐	☐	☐	☐
51lbs to 100lbs……	☐	☐	☐	☐
Over 100lbs…….	☐	☐	☐	☐
Bending…….	☐	☐	☐	☐
Reach below knees……	☐	☐	☐	☐
Reach overhead…….	☐	☐	☐	☐
Squat/kneel……	☐	☐	☐	☐
Use foot controls……...	☐	☐	☐	☐
Climb:				
Stairs……	☐	☐	☐	☐
Ladders…….....	☐	☐	☐	☐
Drive: Car or pickup truck……...	☐	☐	☐	☐
Other work vehicles if applicable (i.e. dump truck, backhoe, etc.)…..	☐	☐	☐	☐

No use of ☐Left ☐Right: ☐ Arm ☐Hand ☐Fingers ☐Other_____

The employee is able to perform repetitive wrist motion with: ☐Left Hand ☐Right Hand ☐Both

The employee is able to perform simple grasping with: ☐Left Hand ☐Right Hand ☐Both

How many total hours is the employee able to work? _____hours in a day _____hours in a week

If the injured worker was prescribed medication, is the injured employee able to safely perform work duties without posing a direct threat to himself, co-workers or the general public which, if applicable, may include operating heavy machinery, driving, or performing safety sensitive duties? ☐ Yes ☐ No ☐Not applicable If no, please describe potential side effects: _____

Physician's further explanation of work abilities/restrictions or why the injured worker is unable to perform any work:

Physician's Name *(print)*:	**Phone Number:**
Physician's Signature:	**Date:**

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