

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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

Work Status	Work/Non-Work Capabilities				
	None at all 0%	Occasional 1-33% 4-6	Frequent 34-66% 6-12	Continuous 67-100% >12	
<input type="checkbox"/> May return to work with no restrictions on _____.	% of 8hr workday or repetitions per hr				
<input type="checkbox"/> May return to work with temporary restrictions*: from _____ to _____.	Sit.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Temporarily unable to work from* _____ to _____.	Stand.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Walk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lift or carry:				
	Up to 10lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	11lbs to 20lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	21lbs to 50lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	51lbs to 100lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Over 100lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pushing/Pulling:				
	Up to 10lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	11lbs to 20lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	21lbs to 50lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	51lbs to 100lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Over 100lbs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Bending.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Reach below knees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Reach overhead.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Squat/kneel.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Use foot controls.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Climb:				
	Stairs.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Ladders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Drive: Car or pickup truck.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other work vehicles if applicable (i.e. dump truck, backhoe, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	No use of <input type="checkbox"/> Left <input type="checkbox"/> Right: <input type="checkbox"/> Arm <input type="checkbox"/> Hand <input type="checkbox"/> Fingers <input type="checkbox"/> Other_____				
	The employee is able to perform repetitive wrist motion with: <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Hand <input type="checkbox"/> Both				
	The employee is able to perform simple grasping with: <input type="checkbox"/> Left Hand <input type="checkbox"/> Right Hand <input type="checkbox"/> 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: