



# Work Comp Associates, Inc.

*Florida's Premier Source for Workers' Compensation Coverage & Information*

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## Physical Capacity Evaluation Form

Revision date: 6/19/2007

### Instructions:

Please complete the following:

1. "Patient Name"
2. "Claim No.": supplied by the carrier's Claims department
3. "Dear Dr."

This form is provided courtesy of Work Comp Associates, Inc.

## PHYSICAL CAPACITY EVALUATION FORM\*

Patient Name: \_\_\_\_\_ Claim No.: \_\_\_\_\_

Dear Dr. \_\_\_\_\_:

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.

1. Current diagnosis of patient: \_\_\_\_\_

Medical prognosis: \_\_\_\_\_

2. When will your patient be released to return to work:

Full Duty on \_\_\_\_\_ Light Duty on \_\_\_\_\_

IF YOUR PATIENT IS RELEASED TO FULL DUTY, DISREGARD QUESTIONS 3 THROUGH 9

3. In an 8-hour workday, your patient can stand/walk:

\_\_\_\_\_ No restrictions

Hours at one time: \_\_\_\_\_ 6-8      \_\_\_\_\_ 4-6      \_\_\_\_\_ 2-4      \_\_\_\_\_ 0-2

Total hours during the day: \_\_\_\_\_ 6-8      \_\_\_\_\_ 4-6      \_\_\_\_\_ 2-4      \_\_\_\_\_ 0-2

4. In an 8-hour workday, your patient can sit:

\_\_\_\_\_ No restrictions

Hours at one time: \_\_\_\_\_ 6-8      \_\_\_\_\_ 4-6      \_\_\_\_\_ 2-4      \_\_\_\_\_ 0-2

Total hours during the day: \_\_\_\_\_ 6-8      \_\_\_\_\_ 4-6      \_\_\_\_\_ 2-4      \_\_\_\_\_ 0-2

5. Your patient can lift/carry: \_\_\_\_\_ No Restrictions

	Unlimited	Occasionally
50 lbs. or more	_____	_____
40 lbs. - 50 lbs.	_____	_____
30 lbs. - 40 lbs.	_____	_____
20 lbs. - 30 lbs.	_____	_____
10 lbs. - 20 lbs.	_____	_____
Up to 10 lbs.	_____	_____

\* Source: 2007 Workers' Compensation Desk Manual by James McConnaughay.

6. Your patient can use hands/arm for repetitive:

\_\_\_\_\_ No Restrictions

	Unlimited	Occasionally
Simple grasping	_____	_____
Pushing/Pulling	_____	_____
Fine Manipulation	_____	_____
Reaching above head	_____	_____
Reaching away from body	_____	_____

7. Your patient can use feet/legs for repetitive movement as in operating foot controls:

\_\_\_\_\_ No Restrictions    \_\_\_\_\_ Yes    \_\_\_\_\_ No

8. Your patient is able to:

	Frequently	Occasionally	Not at all
A. Bend	_____	_____	_____
B. Squat	_____	_____	_____
C. Kneel	_____	_____	_____
D. Climb	_____	_____	_____

9. Is your patient restricted by environmental factors such as heat/cold, dust, dampness, height, etc.?

\_\_\_\_\_ No Restrictions    \_\_\_\_\_ Yes - Please explain: \_\_\_\_\_

10. Is your patient involved with treatment and/or medications that might affect his/her ability to work?

\_\_\_\_\_ No Restrictions    \_\_\_\_\_ Yes - Please explain: \_\_\_\_\_

11. Has your patient reached maximum medical improvement:

\_\_\_\_\_ No    \_\_\_\_\_ Yes, on \_\_\_\_\_

12. Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's signature

Date