WORK CAPACITY FORM

RE: _____ **DEPT:** _____

DOI: _____ **JOB TITLE:** _____

WORK RESTRICTIONS:

LIFTING LIMITED TO:		CARRYING LIMITED TO:		PUSHING/PULLING LIMITED TO:		POSITION LIMITATION:			
☐	No Lifting	☐	No Carrying	☐	No Pushing//Pullinn9	☐	No Exposure to Vibrating Tools	☐	No Repetitive Stooping, Twisting
☐	1-5 lbs.	☐	1-5 lbs.	☐	1-5 lbs.	☐	No Repetitive Finger Motion	☐	or Bending
☐	6-15 lbs.	☐	6-15 lbs.	☐	6-15 lbs.	☐	No Repetitive Wrist Motion	☐	Change Positions as needed
☐	16-25 lbs.	☐	16-25 lbs.	☐	16-25 lbs. -	☐	No Reaching Above Shoulders	☐	Not to Drive Vehicles
☐	26-40 lbs.	☐	26-40 lbs.	☐	26-40 lbs.	☐	No Reaching Below Waist	☐	Avoid Stairs
☐	41-75 lbs.	☐	41-75 lbs.	☐	41-75 lbs.	☐	Avoid Extremes of Neck Motion	☐	Keep wound clean & dry
Other Limitations:								☐	Alt. sitting/standing
Comments:								☐	No use R ☐ L ☐ Arm/Hand

DURATION OF RESTRICTED WORK: _____

WORK STATUS EXPECTED return to FULL duty: _____

EXPECTED return to LIGHT duty: _____

REDUCED HOURS?: TOTAL HRS/DAY _____ DAYS PER WK: _____

☐ **I HAVE REVIEWED THE EMPLOYEE'S ATTACHED JOB DESCRIPTION**

☐ Employee can return to work on _____with **NO restrictions**.

☐ Employee can return to work _____with the ABOVE rrestrictions.

☐ Employee may not return to work until:_____

Medication prescribed due to illness/injury: Yes ____ No _____

If yes, should accommodations be made while on prescribed medication: Yes ____ No ____

If yes, what accommodations: _____

Duration of accommodations: _____ Date scheduled for follow up: _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

PHYSICIAN PRINT NAME : _____ **PHONE:** _____ **FAX:** _____