

# Return to Work/Physical Capability Form

Patient \_\_\_\_\_

Physician \_\_\_\_\_

**Diagnosis** \_\_\_\_\_

**Treatment (needed for OSHA rules and placement)**

- Narcotic analgesic       Anti-inflammatory medication       Sutures  
 Physical therapy       Other \_\_\_\_\_

- Condition:  Improved  
 Symptoms Worse  
 Unchanged  
 Not Applicable

I saw this patient on (date) \_\_\_\_\_ and based on the above description of the patient's current medical problem (check all that apply):

- Return to regular duty on (date) \_\_\_\_\_ .  
 Return to work on (date) \_\_\_\_\_ with restrictions:  
      temporary       permanent  
 Off work until (date) \_\_\_\_\_ .

Patient to be reevaluated: \_\_\_\_\_ days \_\_\_\_\_ weeks.

**Total hours of work per day:**

- 4 hours  
 6 hours  
 8 hours  
 10 hours  
 No restriction  
 Other \_\_\_\_\_

- Heavy work.** Lifting 50 lbs. frequently with occasional lifting and/or carrying objects weighing up to 100 lbs.
- Medium-heavy work.** Lifting 40 lbs. frequently with occasional lifting and/or carrying of objects weighing up to 75 lbs.
- Medium work.** Lifting 25 lbs. frequently with occasional lifting and/or carrying objects weighing up to 50 lbs.
- Light-medium work.** Lifting 20 lbs. frequently with occasional lifting and/or carrying objects weighing up to 30 lbs.
- Light work.** Lifting 10 lbs. frequently with occasional lifting and/or carrying objects weighing up to 20 lbs. Even though the weight lifted may be a negligible amount, this category would include a job that requires walking or standing to a significant degree or involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.
- Sedentary work.** Lifting 10 lbs. maximum and occasionally lifting and/or carrying such articles as files, light packages and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

	Continuously 67-100%	Frequently 34-66%	Occasionally 11-33%	Seldom 1-10%	Restricted 0%
<input type="checkbox"/> Not applicable					
Sit/drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Hand: Specify—Right [R]; Left [L]; Bilateral [B]**

<input type="checkbox"/> Not applicable					
Grasp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pincer grip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist (wrist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/pull w/hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist flexion/extension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Feet: Specify—Right [R]; Left [L]; Bilateral [B]**

Repetitive movements as in operating foot controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- No exposure to moving machinery       No exposure to unprotected heights  
 Avoid wet work       Avoid irritants (specify) \_\_\_\_\_

Patient referred to (physician) \_\_\_\_\_

Other instructions and/or limitations \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_