PHYSICAL ASSESSMENT FORM FOR EARLY RETURN-TO-WORK PROGRAM

To Be Completed By Attending Physician

Please complete and return this form to assist us in accommodating any temporary modified duty restrictions.

Employee's Name:_____ Date of Injury:____/____/_____

Date of Appointment:____/____/____

Employee is expected to return to full duty on:____/____/____

Employee is to return to modified duty on:____/____/_____

In an 8 hour work day, the employee can:

STAND	☐ **1-3 hours**	☐ **3-5 hours**	☐ **5-8 hours**	**____No**
WALK	☐ **1-3 hours**	☐ **3-5 hours**	☐ **5-8 hours**	**____No**
SIT	☐ **1-3 hours**	☐ **3-5 hours**	☐ **5-8 hours**	**____No**
LIFT	☐ **Up to 10 lbs.**	☐ **10-20 lbs.**	☐ **20-50 lbs.**	**____>50 lbs.**

Employee is able to:

LIFT	**____Frequently**	**____Occasionally**	**____Not at all**
BEND	**____Frequently**	**____Occasionally**	**____Not at all**
CARRY	**____Frequently**	**____Occasionally**	**____Not at all**
CLIMB	**____Frequently**	**____Occasionally**	**____Not at all**
KNEEL	**____Frequently**	**____Occasionally**	**____Not at all**
PUSH/PULL	**____Frequently**	**____Occasionally**	**____Not at all**

Employee is able to:

Reach above shoulders ____Yes ____No

Safely drive or operate equipment or machinery ____Yes ____No

With hands and wrists, the Employee is able to do:

KEYBOARDING	**____Frequently**	**____Occasionally**	**____Not at all**
HANDLING FILES	**____Frequently**	**____Occasionally**	**____Not at all**
PUSHING/PULLING	**____Frequently**	**____Occasionally**	**____Not at all**
GRASPING	**____Frequently**	**____Occasionally**	**____Not at all**
FINE MANIPULATION	**____Frequently**	**____Occasionally**	**____Not at all**

Please list all other specific restrictions:

Maximum number of hours per day Employee can work:_____

Date of next appointment: ____/____/____

Physician Signature: _____ Date: ____/____/____