Physical Restrictions and Capabilities Form

Patient Name: _____ **Date Prepared:** _____

Job Title: _____ **Prepared By:** _____

The patient can work: ☐ **FULL DUTY** ☐ **RESTRICTED DUTY** ☐ **UNABLE TO RTW**

☐ 8 hour workday Continuously / With Rest (circle one)
☐ 10 hour workday Continuously / With Rest (circle one)
☐ 12 hour workday Continuously / With Rest (circle one)

	Occasionally 1-3 hours	**Frequently** 3-5 hours	**Continuously** 5+ hours	**Never**
SIT	☐	☐	☐	☐
STAND	☐	☐	☐	☐
WALK	☐	☐	☐	☐
LIFT				
Up to 10 lbs	☐	☐	☐	☐
11–20 lbs	☐	☐	☐	☐
21-50lbs	☐	☐	☐	☐
51-100lbs	☐	☐	☐	☐
CARRY				
Up to 10 lbs	☐	☐	☐	☐
11–20 lbs	☐	☐	☐	☐
21-50lbs	☐	☐	☐	☐
GRASP				
Right	☐	☐	☐	☐
Left	☐	☐	☐	☐
BEND	☐	☐	☐	☐
SQUAT	☐	☐	☐	☐
CRAWL	☐	☐	☐	☐
CLIMB	☐	☐	☐	☐
BALANCE	☐	☐	☐	☐
REACH	☐	☐	☐	☐
PUSH (Light / Medium / Heavy)	☐	☐	☐	☐
PULL (Light / Medium / Heavy)	☐	☐	☐	☐
DRIVING	☐	☐	☐	☐

ACTIVITY RESTRICTIONS INVOLVING	**Total**	**Moderate**	**Mild**	**No Restrictions**
Fixed / Moving Machinery	☐	☐	☐	☐
Cold Climate	☐	☐	☐	☐
Hot Climate	☐	☐	☐	☐
Wet / Humid	☐	☐	☐	☐
Noise	☐	☐	☐	☐
Dust / Fumes	☐	☐	☐	☐

Patient released to return to work with restrictions Date: _____
Estimated return to work without restrictions Date: _____
Restrictions are effective through Date: _____
Has patient reached maximum medical improvement? YES / NO Date: _____
Are the above stated restrictions permanent? YES / NO Date: _____
Can patient work full time? YES / NO **Part time: #hrs/day** _____ Date: _____

COMMENTS: _____

Physician's Signature: _____ Date: _____