ESTIMATED FUNCTIONAL CAPACITY EVALUATION

To be completed by treating physician.

Patient:

Definitions for your reference:

SEDENTARY WORK:	lift 10# maximum and occasionally carry small objects
LIGHT WORK:	lift 20# maximum; frequently lift/carry up to 10#
MEDIUM WORK:	lift 50# maximum; frequently lift/carry up to 25#
HEAVY WORK:	lift 100# maximum; frequently lift/carry up to 50#
VERY HEAVY WORK:	lift in excess of 100#; frequently lift/carry 50#

I WOULD ESTIMATE THIS PERSON TO BE ABLE TO:

	Never	Occasionally (1-33%)	Frequently (34-66%)	Continuously (67-100%)
1. LIFT:				
a. up to 10#				
b. 11 - 24#				
c. 25 - 34#				
d. 35 - 50#				
e. 51 - 74#				
f. 75 - 100#				
2. CARRY:				
a. up to 10#				
b. 11 - 24#				
c. 25 - 34#				
d. 35 - 50#				
e. 51 - 74#				
f. 75 - 100#				
3. PERFORM THE FOLLOWING TASKS:				
Push/Pull – Seated				
Push/Pull – Standing				
Bend				
Squat				
Crawl				
Climb				
Reach above shoulder level				

4. ASSUMING AN 8-HOUR WORKDAY WITH TWO 15-MINUTE BREAKS AND AN HOUR MEAL BREAK, I WOULD EXPECT THIS PERSON TO BE ABLE TO:

*Circle number of hours for each activity. NOTE: Total does **not** have to equal 8 hours.*

Activity	Number of Hours								Continuously	With Rests
Sit	1	2	3	4	5	6	7	8	☐	☐
Stand	1	2	3	4	5	6	7	8	☐	☐
Walk	1	2	3	4	5	6	7	8	☐	☐
Alternately Sit/Stand	1	2	3	4	5	6	7	8	☐	☐

5. CAN PERSON USE HANDS FOR REPETITIVE ACTIONS SUCH AS:

	Simple Grasping		Firm Grasping		Fine Manipulating	
Right:	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
Left:	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

Estimated Grip Strength: Right: # Left: #

6. CAN PERSON USE FEET FOR REPETITIVE MOVEMENTS AS IN OPERATING FOOT CONTROLS?

Right (Alone)		Left (Alone)		Both (Simultaneously)	
Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

7. ANY RESTRICTIONS OF ACTIVITIES INVOLVED?

Activity	None	Mild	Moderate	Total
Unprotected Heights				
Being around moving machinery				
Exposure to marked changes in temperature and humidity				
Driving automotive equipment				
Exposure to dust; fumes; gases				

8. CAN PERSON CONTINUE IN CURRENT JOB? Yes ☐ No ☐

If not, can person return to other work according to restrictions defined above? Yes ☐ No ☐

Can the person work full-time? Yes ☐ No ☐

If not, can the person work part-time? Yes ☐ No ☐

If person can work part-time but not full-time, please estimate schedule, in hours per day and days per week:

Disability rating (if applicable): %

9. COMMENTS:

Physician Name:

Address:

City, State, Zip:

Telephone:	Field of Specialty:	License No.:
Signature:		Date: