

**PHYSICAL CAPACITIES FORM**

PATIENT NAME: \_\_\_\_\_ EMPLOYER: Muhlenberg College D/L: \_\_\_\_\_  
CLAIM #: WC007M2008 JOB TITLE: \_\_\_\_\_

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient. Please FAX your response to 800-641-6330. Thank you for your cooperation in this matter

1. In an 8-hour workday, patient can stand/walk:  No restrictions  
(Hours at one time) (Total hours during day)  
         
0-2 2-4 4-5 6-8 0-2 2-4 4-6 6-8
2. In an 8-hour workday, patient can sit:  No restrictions  
(Hours at one time) (Total hours during day)  
         
0-2 2-4 4-5 6-8 0-2 2-4 4-6 6-8
3. In an 8-hour workday, patient can drive car/truck:  No restrictions  
(Minutes at one time) (Hours at one time)  
    
10-30 30-60 1-3
4. Patient can lift/carry:  No restrictions or above  
Maximum lbs.: 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80  
Frequently:                 
Occasionally:
5. Patient can use hands for repetitive:  No restrictions  
A. Simple Grasping  B. Pushing & Pulling  C. Fine manipulation   
Yes No Yes No Yes No
6. Patient can use feet for repetitive movement as in operating foot controls:  No restrictions  
 Yes  No
7. Patient is able to:  
Frequently Occasionally Not at all  
A. Bend     
B. Squat     
C. Kneel     
D. Climb     
E. Reach
8. Is patient restricted by environmental factors, such as heat/cold, dust, dampness, height, etc.?  
 No restriction  
 Yes – Please explain \_\_\_\_\_
9. Is patient involved with treatment and/or medication that might affect his/her ability to work?  
 No restriction  
 Yes – Please explain \_\_\_\_\_
10. When will patient be released to return to work:  
Light duty \_\_\_\_\_ Full duty \_\_\_\_\_
11. Will patient be required to use any assistive devices or braces?  
 No restrictions  
 Yes – Please explain \_\_\_\_\_
12. **Recommended treatment plan:** \_\_\_\_\_
13. Expected Discharge date: \_\_\_\_\_
14. Next Appointment: \_\_\_\_\_

Physician's Signature

Date