

# PHYSICAL AND FUNCTIONAL EVALUATION FORM

Sent to: Dr. \_\_\_\_\_

Employee/Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Probable duration: \_\_\_\_\_

1. Can the individual perform all the duties of his/her job per the attached job description? (Circle one) Y or N

If Yes, date the individual can return to full duty: Date: \_\_\_\_\_ Go to item 10.

If No, please complete items 3-9.

2. In his/her current physical condition, how many hours can the individual perform the following functions in an 8 hour day? (circle one):

Sit	1	2	3	4	5	6	7	8	Crawling	1	2	3	4	5	6	7	8
Stand	1	2	3	4	5	6	7	8	Climbing	1	2	3	4	5	6	7	8
Walk	1	2	3	4	5	6	7	8	Reach O/H	1	2	3	4	5	6	7	8
Balancing	1	2	3	4	5	6	7	8	Pushing	1	2	3	4	5	6	7	8
Stooping	1	2	3	4	5	6	7	8	Pulling	1	2	3	4	5	6	7	8
Kneeling	1	2	3	4	5	6	7	8	Lifting/Carry	1	2	3	4	5	6	7	8
Crouching	1	2	3	4	5	6	7	8	Maximum lifting weight	10	20	50	100	lbs			

3. Individual can use hands for:  
(Occasionally means up to 33% of the time, Frequently means up to 34-66% and Continuously means 67-100%)

	Right	Left	Both	Occ.	Freq.	Cont.
Fine manipulation	<input type="checkbox"/>					
Medium dexterity	<input type="checkbox"/>					
Power grip	<input type="checkbox"/>					
Pushing/pulling	<input type="checkbox"/>					
Forearm rotational movement	<input type="checkbox"/>					
Bimanual dexterity	<input type="checkbox"/>					
Dominant hand	<input type="checkbox"/>					

4. Use of feet to operate controls:  Right  Left  Both  Occ.  Freq.  Cont.

5. Any visual limitations:  Right  Left  Both  Occ.  Freq.  Cont.

6. Has the individual reached maximum medical improvement? (Circle one) Y or N

If no, when expected? Date: \_\_\_\_\_

7. Have you prescribed any medications that would interfere with the employee's ability to perform the job? (Circle one) Y or N

8. Can the individual drive a car? (Circle one) Y or N

9. Comments placement: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone No \_\_\_\_\_