

Report of Workability



You must return this completed form to your employer as requested, or your return to work may be delayed or denied.

Employee name: _____ Work Comp Claim #: _____ Employee ID #: _____

Treatment Date: ____/____/____ Illness/Injury and Diagnosis Code: _____ Date of Injury: ____/____/____

☐ Work Related ☐ Not Work Related ☐ Undetermined

☐ Return to work with no limitations ☐ Immediately or ☐ Beginning ____/____/____
☐ Return to work with limitations on ____/____/____ through or next reassessment ____/____/____
☐ Unable to work from ____/____/____ through or next reassessment ____/____/____

Employee is released to work 1 2 3 4 5 6 7 8 9 10 + hours per day (circle one)

Employee is released to work 1 2 3 4 5 + days per week (circle one)

Employee is released to work overtime: Yes No

Has the employee been prescribed any medication which could cause drowsiness or impair ability to remain alert and aware? ☐
 YES ☐ NO If yes, medication: _____

If yes, are there any special instructions given to the employee as to when or how to take the medication to limit impact to job duties? Please describe: _____

☐ Return to clinic on ____/____/____ Time: _____

EMPLOYEE'S CAPABILITIES

If restricted from performing a work activity for a reduced time period during the day, this means an employee is not able to perform that activity more than identified for the entire shift. Restrictions in effect 24 hours per day.

	Not at all	<1 hr	1-3 hrs	3-6 hrs	6-7 hrs	8+ hrs		Not at all	<1 hr	1-3 hrs	3-6 hrs	6-7 hrs	8+ hrs		Not at all	<1 hr	1-3 hrs	3-6 hrs	6-7 hrs	8+ hrs
Lift/Carry							Drive							Upper Extremities						
0-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Car/pickup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-40 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41-60 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Positions							Firm gripping/grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
>60 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kneel/Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Outstretch arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull							Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overhead reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vibrating tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-75 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>							
76-100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								Sensory/Environmental						
>100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trunk Comments:							Limitations	Yes	No	If yes, explain			
Climb														Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Enter/exit heavy equipment with three-point contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck Comments:							Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Ladder/stair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								Inside work	<input type="checkbox"/>	<input type="checkbox"/>	_____			
														Outside work	<input type="checkbox"/>	<input type="checkbox"/>	_____			
														Wet/humid	<input type="checkbox"/>	<input type="checkbox"/>	_____			
														Noise/vibration	<input type="checkbox"/>	<input type="checkbox"/>	_____			
														Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____			

Other Activity Restrictions: ex. being around moving machinery, driving automotive equipment, use of durable medical equipment): _____

This certification is being sought only with regard to the particular health condition that caused the employee's need for the leave. If a list of the essential functions of the employee's position is included with this form, please consider these essential functions as you review the employee's workability.

No further anticipated care and released from care: Yes No

Clinic Name/Address

Fax

I certify I have reviewed the job duties & description. Physician's name: Print and Signature

Date