

# ESTIMATED FUNCTIONAL CAPACITY EVALUATION

*To be completed by treating physician.*

Patient: _____
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*Definitions for your reference:*

<b>SEDENTARY WORK:</b>	lift 10# maximum and occasionally carry small objects
<b>LIGHT WORK:</b>	lift 20# maximum; frequently lift/carry up to 10#
<b>MEDIUM WORK:</b>	lift 50# maximum; frequently lift/carry up to 25#
<b>HEAVY WORK:</b>	lift 100# maximum; frequently lift/carry up to 50#
<b>VERY HEAVY WORK:</b>	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%)
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**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	<input type="checkbox"/>	<input type="checkbox"/>
Stand	1	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>
Walk	1	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>
Alternately Sit/Stand	1	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>

<b>5. CAN PERSON USE HANDS FOR REPETITIVE ACTIONS SUCH AS:</b>						
	Simple Grasping		Firm Grasping		Fine Manipulating	
Right:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Left:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Estimated Grip Strength: Right:           #    Left:           #						
<b>6. CAN PERSON USE FEET FOR REPETITIVE MOVEMENTS AS IN OPERATING FOOT CONTROLS?</b>						
<b>Right (Alone)</b>		<b>Left (Alone)</b>		<b>Both (Simultaneously)</b>		
Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
<b>7. ANY RESTRICTIONS OF ACTIVITIES INVOLVED?</b>						
	<b>Activity</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Total</b>	
	Unprotected Heights					
	Being around moving machinery					
	Exposure to marked changes in temperature and humidity					
	Driving automotive equipment					
	Exposure to dust; fumes; gases					
<b>8. CAN PERSON CONTINUE IN CURRENT JOB? Yes <input type="checkbox"/> No <input type="checkbox"/></b>						
If not, can person return to other work according to restrictions defined above? Yes <input type="checkbox"/> No <input type="checkbox"/>						
Can the person work full-time? Yes <input type="checkbox"/> No <input type="checkbox"/>						
If not, can the person work part-time? Yes <input type="checkbox"/> No <input type="checkbox"/>						
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):            %						
<b>9. COMMENTS:</b>						
Physician Name:						
Address:						
City, State, Zip:						
Telephone:		Field of Specialty:		License No.:		
Signature:				Date:		