ESTIMATED PHYSICAL CAPABILITIES FORM FOR NEW YORK STATE EMPLOYEES

Name of Physician	Name of Employee

Note: Important Information on Reverse

STRUCTIONS: ***If the employee is found to be 50% or less disabled, please complete this form based on your estimation of his/her current physical capabilities.***

1. Medical Diagnosis: _____

2a. In an eight-hour workday, how many hours can this employee: (*Please check appropriate boxes.*)

Sit	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8	☐ Continuously	☐ With Rests
Stand	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8	☐ Continuously	☐ With Rests
Walk	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8	☐ Continuously	☐ With Rests

b. In a given day, for how many total hours can this employee sit, stand, and/or walk in combination?

☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16

3. Other Capabilities: (*Please check appropriate boxes.*)

	Never	Occasionally	Frequently	Continuously
Lift				
00–10 lbs.	☐	☐	☐	☐
11–20 lbs.	☐	☐	☐	☐
21–50 lbs.	☐	☐	☐	☐
51–100 lbs.	☐	☐	☐	☐
Carry				
00–10 lbs.	☐	☐	☐	☐
11–20 lbs.	☐	☐	☐	☐
21–50 lbs.	☐	☐	☐	☐
51–100 lbs.	☐	☐	☐	☐
and	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Run	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate a motor vehicle	☐	☐	☐	☐

Upper Extremities:

Which hand is dominant? ☐ Right ☐ Left

Can this employee perform repetitive actions such as:

	Simple Grasping	Pushing & Pulling	Fine Manipulation
RIGHT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
LEFT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Lower Extremities:

Use of feet/legs for repetitive movement, as in operation of foot controls and motor vehicles.

Right Extremity	Left Extremity	Simultaneous
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4. Work Environment Restrictions:
   - Can this employee:
     - Be exposed to marked changes in temperature and humidity? ☐ Yes ☐ No
     - Be exposed to unprotected heights? ☐ Yes ☐ No
     - Be around moving machinery? ☐ Yes ☐ No
5. Other Restrictions:
   - Can this employee restrain combative clients? ☐ Yes ☐ No
   - Does this employee have any visual or hearing impairment requiring accommodation? ☐ No ☐ Yes *If "Yes," please explain:* _____

6. Based on your examination(s) of this employee, are there any known problems of a general nature, including any medications prescribed for the diagnosis listed, that would interfere with this employee returning to work?
   ☐ No ☐ Yes *If "Yes," please explain:* _____

When, in your estimation, will this employee be ready to return to full duty? Date_____

Comments: _____

Physician's Signature	Telephone Number ( )	Date

(2/96)