Work Capabilities Evaluation – Physician Statement

Modified return to work assignments may be available to employees who are unable to perform all required job duties. To help assess the employee's capabilities & facilitate available placement opportunities, we need your assistance as _____ Physician. Job Title:_____

☐ Will allow employee to return to work as of _____ (date) **Full Duty / No Restrictions.**

☐ Will allow employee to return to work as of _____ (date) **With Restrictions Identified Below**, which are expected to last until _____ (date).

Date of follow-up visit: _____

If returning to Modified Duty (less than full duty per the attached job description), please complete ALL of the information below:

Criteria: Normal work schedule – **NO Overtime or On-Call** *(please check the appropriate boxes below)*

	Max Hours per day: 0 | 2 | 4 | 6 | 8 | Other		Max Hours per day: 0 | 2 | 4 | 6 | 8 | Other
Standing:	☐ ☐ ☐ ☐ ☐	Walking:	☐ ☐ ☐ ☐ ☐
Sitting:	☐ ☐ ☐ ☐ ☐	Climbing stairs/ladders:	☐ ☐ ☐ ☐ ☐
Kneeling/Squatting	☐ ☐ ☐ ☐ ☐	Grasping/Squeezing:	☐ ☐ ☐ ☐ ☐
Bending/Stooping	☐ ☐ ☐ ☐ ☐	Wrist flexion/extension:	☐ ☐ ☐ ☐ ☐
Pushing/Pulling:	☐ ☐ ☐ ☐ ☐	Reaching:	☐ ☐ ☐ ☐ ☐
Twisting:	☐ ☐ ☐ ☐ ☐	Overhead Reaching:	☐ ☐ ☐ ☐ ☐
Keyboarding:		Other:	

Lifting/Carrying Restrictions (if any):

☐ May not lift/carry objects more than _____ lbs. for more than _____ hours per day

☐ May not perform any lifting/carrying

Medication Restrictions (if any):

☐ Medication may make drowsy (possible safety/driving issue)

Please provide any applicable restrictions not addressed, including non-physical demands and/or Environmental restrictions:_____

Physician Name (please print):_____ Phone:_____

Physician Signature:_____ Date: _____

Human Resources Office: 830-386-2244 ~ Fax: 830-401-2478