Form Approved
OMB NO. 0960-0662

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

NAME OF INDIVIDUAL **SOCIAL SECURITY NUMBER**

To assist us in determining this individual's ability to do work-related activities, please give us your professional opinion of what the individual can still do despite his her impairment(s). The opinion should be based on your findings with respect to medical history, clinical and laboratory findings (or lack thereof), diagnosis, prescribed treatment and response, expected duration and prognosis.

For each activity shown below:
(1) Check the appropriate block;
(2) Respond to the questions about the individual's ability to perform the activity; and
(3) Identify the factors (e.g., the particular medical signs, laboratory findings, or other factors described above) that support your assessment of any limitations.

IT IS VERY IMPORTANT TO DESCRIBE THE FACTORS THAT SUPPORT YOUR ASSESSMENT. WE ARE REQUIRED TO CONSIDER THE EXTENT TO WHICH YOUR ASSESSMENT IS SUPPORTED.

EXERTIONAL LIMITATIONS

1. Are **LIFTING/CARRYING** affected by the impairment? ☐ No ☐ Yes

If "yes," how many pounds can the individual lift and/or carry?
Frequently means occurring one-third to two-thirds of an 8-hour workday (cumulative, not continuous).
Occasionally means occurring from very little up to one-third of an 8-hour workday (cumulative, not continuous).

Occasionally lift and/or carry (including upward pulling)
(maximum) -when less than one-third of the time or less than 10 pounds, explain the amount (time/pounds) in item 5.

☐ less than 10 pounds
☐ 10 pounds
☐ 20 pounds
☐ 25 pounds
☐ 50 pounds
☐ 100 pounds or more

Frequently lift and/or carry (including upward pulling)
(maximum) - when less than two-thirds of the time or less than 10 pounds. explain the amount (time/pounds) in item 5.

☐ less than 10 pounds
☐ 10 pounds
☐ 20 pounds
☐ 25 pounds
☐ 50 pounds
☐ 100 pounds or more

2. Are **STANDING and/or WALKING** affected by the impairment? ☐ No ☐ Yes

If "yes," how many hours total (with normal breaks) can the individual stand andlor walk?

☐ less than 2 hours in an 8-hour workday (If less than two hours selected provide explanation of the precise limitation opined below)
☐ at least 2 hours in an 8-hour workday
☐ about 6 hours in an 8-hour workday
☐ medically required hand-held assistive device is necessary for ambulation

3. Is **SITTING** affected by the impairment? ☐ No ☐ Yes

☐ less than 6 hours in an 8-hour workday
☐ about 6 hours in an 8-hour workday
☐ must periodically alternate sitting and standing to relieve pain or dismmfort. (If checked, explain in item 5.)

4. Is **PUSHING and/or PULLING** affected by the impairment? ☐ No ☐ Yes
(including operation of hand and/or foot controls)
If "yes," check appropriate block.
☐ limited in upper extremities (describe nature and degree)
☐ a limited in lower extremities (describe nature and degree)

5. What medical/clinical finding(s) support your conclusion in item 1-4 above?

POSTURAL LIMITATIONS
How often can the individual perform the following **POSTURAL** activities?
Frequently means occurring one-third to two-thirds of an 8-hour workday (cumulative, not continuous).
Occasionally means occurring from very little up to one-third of an 8-hour workday (cumulative, not continuous).

	Frequently	Occasionally	Never
1. Climbing - ramps/stairs/ladder/rope/scaffold	☐	☐	☐
2. Balancing	☐	☐	☐
3. Kneeling	☐	☐	☐
4. Crouching	☐	☐	☐
5. Crawling	☐	☐	☐
6. Stooping	☐	☐	☐

When less than two-thirds of the time for frequently or less than one-third for occasionally, fully describe and explain.

MANIPULATIVE LIMITATIONS

Are the following **MANIPULATIVE** functions affected by the impairment:

	LIMITED	UNLIMITED
1. Reaching all directions (including overhead)	☐	☐
2. Handing (gross manipulation)	☐	☐
3. Fingering (fine manipulation)	☐	☐
4. Feeling (skin receptors)	☐	☐

If there are manipulative limitations described as “limited”, please check how often the individual can do the following.

☐ REACHING	☐ OCCASIONALLY	☐ FREQUENTLY	☐ CONSTANTLY
☐ HANDLING	☐ OCCASIONALLY	☐ FREQUENTLY	☐ CONSTANTLY
☐ FINGERING	☐ OCCASIONALLY	☐ FREQUENTLY	☐ CONSTANTLY
☐ FEELING	☐ OCCASIONALLY	☐ FREQUENTLY	☐ CONSTANTLY

5. Describe how the activities checked “limited” are impaired and the basis of additional manipulative limitations. What medical/clinical findings support your conclusions?

VISUAL/COMMUNICATIVE LIMITATIONS

Are the following functions affected by the impairment?

	LIMITED	UNLIMITED
1. Seeing	☐	☐
2. Hearing	☐	☐
3. Speaking	☐	☐

4. Describe how the faculties checked “limited” are impaired.

ATTENTION/CONCENTRATION

Is it medically reasonable to expect that this patient's ability to maintain attention and concentration on work tasks throughout an 8 hour day is significantly compromised by pain. prescribed medication or both?

ENVIRONMENTAL LIMITATIONS

Are the following **ENVIRONMENTAL LIMITATIONS** caused by the impairment?

	LIMITED	UNLIMITED
1. Temperature Extremes	☐	☐
2. Noise	☐	☐
3. Dust	☐	☐
4. Vibration	☐	☐
5. Humidity/Wetness	☐	☐
6. Hazards (machinery, heights, ...)	☐	☐
7. Fumes, odors, chemicals, gases	☐	☐

8. Describe how the environment factors impair activities and identify hazards to be avoided. What medical/clinical findings support your conclusions?

Physician's Signature　　Medical Specialty　　Date

PRIVACY ACT STATEMENT

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(6), 1614(a)(3)(h)(1) and1631(d)(1) of the Social Security Act. The information on this form is needed by Social Security to complete processing of the named patient's claim. While giving us the information on this form is voluntary, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim. Although the information you furnish on this form is almost never used for any purpose other than making a determination about disability, such information may be disclosed by Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange information between Social Security and another agency.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA. 1338 Annex Building, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***