

ESTIMATED FUNCTIONAL CAPACITY EVALUATION

To be completed by treating physician.

Patient:

Definitions for your reference:

SEDENTARY WORK:

LIGHT WORK:

MEDIUM WORK:

HEAVY WORK:

VERY HEAVY WORK:

lift 10# maximum and occasionally carry small objects

lift 20# maximum; frequently lift/carry up to 10#

lift 50# maximum; frequently lift/carry up to 25#

lift 100# maximum; frequently lift/carry up to 50#

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	☐	☐
Stand	1	2	3	4	5	6	7	8	☐	☐
Walk	1	2	3	4	5	6	7	8	☐	☐
Alternately Sit/Stand	1	2	3	4	5	6	7	8	☐	☐

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