Name: _____ Date of Injury: _____

Diagnosis: _____

Prognosis:

- ☐ Full duty as of: _____
- ☐ Transitional duty as of: _____ (see below)

Activity	**May Perform**		**Comments: time limitation, left/right, etc.**
	Yes	No	
Lift/ Carry			☐ 0-5# ☐5-10# ☐11-25# ☐26-50# ☐51-100#
Push/Pull			☐0-25# ☐26-50# ☐51-75# ☐76-100# ☐Only on wheels
Sitting			
Standing			___ minutes/hour or ___hours/day
Walking			___ minutes/hour or ___hours/day
Bending			Limited to _____degrees at waist
Twisting/rotation			
Grasping/Gripping			
Fine manipulation (hands)			
Crimping			
Repetitive wrist use			
Kneeling/Squatting			
Use of Vibrating Tools			
Reaching/Overhead Work			
Climbing ladder/stairs			
Use of feet (foot controls)			
Visual			☐No tasks requiring binocular vision
Hearing			
Other			

☐ Alternate standing and sitting frequently
☐ No use of right / left _____
☐ Must keep _____elevated
☐ Sitting job only
☐ Must wear brace/splint at work
☐ May not operate a motor vehicle/forklift/machinery

☐ Taking medications during the workday that may cause drowsiness (alternative options unavailable)
→Caution driving, working at heights, working with machinery/tools that are sharp or otherwise require mental alertness or muscular coordination. Employee understands that he/she is responsible for getting to work safely.

Provider Name: _____ Date: _____

Provider Signature: _____