Work Assessment Form

To Be Completed by the Treating Physician

Claimant: _____ SSN/ID: _____

Date of Injury: _____ Date of evaluation: _____

Diagnosis/ condition (brief explanation): _____

Is the injury or illness causally related to the worker's employment? ☐ Yes ☐ No

What is the *current* percentage (0-100%) of temporary disability? _____

Evidence of preexisting condition? ☐ Yes ☐ No If yes, please explain: _____

_____

Anticipated date of discharge from your care OR anticipated date of MMI: _____

Please outline your current treatment plan:

_____

_____

Anticipated RTW Light Duty: _____ Anticipated RTW Full Duty: _____

Based on my assessment and treatment of this injury, I recommend:

- Can the employee work an 8-hour day? ☐ Yes ☐ No If no, how many hours / day? _____
- In an 8-hour day, employee can: (circle full capacity for each)

Sit	1	2	3	4	5	6	7	8	Hours/ day
Stand	1	2	3	4	5	6	7	8	Hours/ day
Walk	1	2	3	4	5	6	7	8	Hours/ day

- Employee can lift / carry: (Please check as appropriate)

	Not at this time		Occasionally		Frequently		No Restriction	
	Lift	Carry	Lift	Carry	Lift	Carry	Lift	Carry
0-10 lb.	☐	☐	☐	☐	☐	☐	☐	☐
11-25 lb.	☐	☐	☐	☐	☐	☐	☐	☐
26-50 lb.	☐	☐	☐	☐	☐	☐	☐	☐
51-100 lb.	☐	☐	☐	☐	☐	☐	☐	☐
100+	☐	☐	☐	☐	☐	☐	☐	☐

- Employee is able to: (please check all that apply)

	Not at this time	Occasionally	Frequently	No Restriction
	0%	1-33%	34-66%	67-100%
Balance	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Use Foot	☐	☐	☐	☐

- Employee can use upper extremities for repetitive: (check as appropriate)

Simple Grasp	Firm Grasp	Fine Manipulation	Pushing / Pulling	(Circle Appropriate)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Right ☐ Left

- Employee can use lower extremities for repetitive movement such as foot controls:
  Right ☐ Yes ☐ No Left ☐ Yes ☐ No

Can the employee drive or independently use public transportation? ☐ Yes ☐ No

Employee is released to work as of: ___/___/_____ ☐ With ☐ Without restrictions noted above.

Date of next evaluation: ___/___/_____

Medical Provider's Signature: _____ Date: ___/___/_____

Print Provider's Name: _____ Provider's Phone Number: (_____) _____- _____