

ATTENDING PHYSICIAN'S STATEMENT (PHYSICAL)

Name of Patient: _____

M F

Date of Birth: _____ SSN: _____

To determine your patient's ability to do *work-related activities on a day-to-day basis in a regular work setting*, please give us your opinion -- **based on your examination** -- of how your patient's physical capabilities are affected *by the impairment(s)*. Do not consider your patient's age, sex or work experience. Consider the medical history, the chronicity of findings (or lack thereof), symptoms (*including differing individual tolerances for pain, etc.*), and the expected duration of any work-related limitations.

For each activity shown below:

- (1) Indicate your patient's ability to perform the activity; and
- (2) Identify the particular medical findings (e.g., physical examination findings, x-ray findings, laboratory test results, history, symptoms (including pain), etc.) that support your opinion regarding any limitations.

IT IS IMPORTANT THAT YOU RELATE PARTICULAR MEDICAL FINDINGS TO ANY REDUCTION IN CAPACITY; THE USEFULNESS OF YOUR OPINION DEPENDS ON THE EXTENT TO WHICH YOU DO THIS.

=====

1. Maximum ability to lift and carry on an *occasional* basis (no more than 1/3 of an 8-hour day).

- No limitation 100# 50# 20# 10# less than 10#

2. Maximum ability to lift and carry on a *frequent* basis (1/3 to 2/3 of an 8-hour day).

- No limitation 50# 25# 10# less than 10#

3. Maximum ability to stand and walk (with normal breaks) during an 8-hour day.

- No limit about 6 hrs. about 4 hrs. about 3 hrs. about 2 hrs. less than 2 hrs.

4. Maximum ability to sit (with normal breaks) during an 8-hour day.

- No limit about 6 hrs. about 4 hrs. about 3 hrs. about 2 hrs. less than 2 hrs.

5. If your patient must periodically alternate sitting, standing or walking to relieve discomfort:

How long can your patient *sit* before changing position? 0 5 10 15 20 30 45 60 90
Minutes

How long can your patient *stand* before changing position? 0 5 10 15 20 30 45 60 90
Minutes

How *often* must your patient *walk around*? Frequency: 0 5 10 15 20 30 45 60 90
Minutes

How *long* must your patient *walk each time*? Duration: 0 5 10 15 20 30 45 60 90
Minutes

Does your patient need the opportunity to shift *at will* from sitting or standing/walking? Yes No

6. *Will your patient sometimes need to lie down at unpredictable intervals during an 8 hour working shift?* Yes No

If yes, how often do you think this will happen? _____

7. What medical findings support the limitations described above? _____

8. How often can your patient perform the following *postural activities*?

	*Frequently	**Occasionally	Never	
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stoop (Bend)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb stair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Frequently: from 1/3 to 2/3 of an 8 hour day
Climb ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	**Occasionally: from very little up to 1/3 of an 8 hour day

What medical findings support this? _____

9. Are the following *PHYSICAL FUNCTIONS* affected by the impairment?

Reaching (including overhead)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Handling (gross manipulation)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fingering (fine manipulation)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Feeling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pushing/pulling	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Key Boarding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient's Dominant Hand is:	<input type="checkbox"/> Left	<input type="checkbox"/> Right

A. How are these physical functions affected? _____

B. What medical findings support this? _____

10.

ENVIRONMENTAL RESTRICTIONS	NO RESTRICTION	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extreme heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fumes, odors, dusts, gases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soldering fluxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvents/cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List other irritants or allergens: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. State any other work-related activities which are affected by the impairment such as need for assistive device for ambulation, need to elevate leg, limits on kneeling, crawling, balancing, seeing, hearing or speaking, or limitations related to a mental impairment. What medical findings support this?

12. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

- | | | |
|--|---|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> About two days per month | <input type="checkbox"/> About four days per month |
| <input type="checkbox"/> About one day per month | <input type="checkbox"/> About three days per month | <input type="checkbox"/> More than four days per month |

Date

Physician's Signature

Printed Name