

ESTIMATED PHYSICAL CAPABILITIES FORM--SECURITY SERVICES AND SUPERVISORS

Name of Physician

Name of Employee

Note: Important Information on Reverse

INSTRUCTIONS: If the employee is found to be 50% or less disabled, please complete this form based on your estimation of her current physical capabilities.

Medical Diagnosis: _____

2a. In an eight hour workday, how many hours can this employee: (Please check appropriate boxes.)

Sit	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> With Rests
Stand	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> With Rests
Walk	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> With Rests

b. In a given day, for how many total hours can this employee sit, stand, and/or walk in combination?
☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16

3. Other Capabilities: (Please check appropriate boxes.)

Never Occasionally Frequently Continuously

Lift				
00 - 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 - 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 - 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 - 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carry				
00 - 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 - 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 - 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 - 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Run	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate a motor vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Upper Extremities:

Which hand is dominant? ☐ Right ☐ Left
 Can this employee perform repetitive actions such as:

	Simple Grasping	Pushing & Pulling	Fine Manipulation
RIGHT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
LEFT	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Lower Extremities:

Use of feet/legs for repetitive movement, as in operation of foot controls and motor vehicles.

Right Extremity	Left Extremity	Simultaneous
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Work Environment Restrictions:

• Can this employee:

Be exposed to marked changes in temperature and humidity?

☐ Yes ☐ No

Be exposed to unprotected heights?

☐ Yes ☐ No

Be around moving machinery?

☐ Yes ☐ No

5. Other Restrictions:

• Can this employee restrain combative clients?

☐ Yes ☐ No

• Does this employee have any visual or hearing impairment requiring accommodation? ☐ No ☐ Yes If "Yes," please explain: _____

6. Based on your examination(s) of this employee, are there any known problems of a general nature, including any medications prescribed for the diagnosis listed, that would interfere with this employee returning to work?
☐ No ☐ Yes If "Yes," please indicate: _____

When, in your estimation, will this employee be ready to return to full duty?

Date: _____

Comments: _____

Physician's Signature

Telephone Number
()

Date

LIMITED DUTY PROGRAM

New York State and Council 82, AFSCME, AFL-CIO, negotiated a Limited Duty Program, as part of the employer-provided benefits associated with workers' compensation disabilities, in the 1991-95 agreements.

This program allows employees in the Security Services and Security Supervisors Units, who have been disabled temporarily due to occupational accidents, to return to work prior to full recovery and work in assignments that meet both the needs of the agency and the medical limitations of the employees.

Employees benefit from this Program by returning to work and becoming productive more quickly, thus enhancing the recuperation process. Agencies benefit from this Program because they have the services of employees who would otherwise be unable to return to work.

When an employee's level of disability is classified at 50% or less (mildly or moderately disabled), the employee is qualified for a limited duty assignment. The agency will use the information provided on this form by the evaluating physician to design a limited duty assignment that is consistent with the employee's limitations and capabilities. Usually an assignment will be given to an employee in blocks of time of no more than 45 days each until the employee has fully recovered and returns to his/her regular assignment.

During the period of limited duty, the employee will be expected to provide periodic medical documentation from the attending physician to verify that the employee's medical condition and the assignment remain consistent and to confirm full recovery prior to return to the regular job assignment.

Questions concerning the information on this form should be directed to the evaluating physician at the telephone number listed. Questions concerning the limited duty assignment should be directed to the employee's agency.