NEW YORK STATE ESTIMATED PHYSICAL CAPABILITIES FORM

Name of Physician	Name of Employee

INSTRUCTIONS: ***Please complete the following items based on your estimation of this employee's physical capabilities.***

1. **Medical Diagnosis:** _____

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

Sit	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐ Continuously	☐ With Rests
Stand	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐ Continuously	☐ With Rests
Walk	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐ Continuously	☐ With Rests

b. Can this employee sit, stand and/or walk in combination for an eight hour workday? ☐ Yes ☐ No

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

	Never	Occasionally (0 - 33%)	Frequently (34 - 66%)	Continuously (67 - 100%)
Lift				
0 - 10 lbs.	☐	☐	☐	☐
11 - 20 lbs.	☐	☐	☐	☐
21 - 50 lbs.	☐	☐	☐	☐
51 - 100 lbs.	☐	☐	☐	☐
Carry				
0 - 10 lbs.	☐	☐	☐	☐
11 - 20 lbs.	☐	☐	☐	☐
21 - 50 lbs.	☐	☐	☐	☐
51 - 100 lbs.	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Run	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate a motor vehicle	☐	☐	☐	☐

Upper Extremities:

Which hand is dominant? ☐ Right ☐ Left

Can this employee perform repetitive actions such as:

	Simple Grasping	Pushing & Pulling	Fine Manipulation
RIGHT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
LEFT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Lower Extremities:

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

Right Extremity	Left Extremity	Simultaneous
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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 exposed to dust, fumes and gases? ☐ Yes ☐ No
     - Be around moving machinery? ☐ Yes ☐ No

5. **Other Restrictions:**
   - Does this employee have any visual or hearing impairment requiring accommodation? ☐ No ☐ Yes *If "Yes," please explain:* _____
   - Can this employee restrain combative patients/clients? ☐ Yes ☐ No

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 explain:* _____

7. When will this employee be physically ready to return to full duty? Date _____
   When will this employee be physically ready to return to alternate duty? Date _____

8. **Comments:** _____

Physician's Signature	Telephone Number ( )	Date