

ESTIMATED PHYSICAL CAPABILITIES FOR NON-PROFESSIONAL, SCIENTIFIC & TECHNICAL

Name of Physician _____	Name of Employee _____
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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 his/her current physical capabilities.*

1. 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	Never	Occasionally	Frequently	Continuously
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	Never	Occasionally	Frequently	Continuously
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"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<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 explain:* _____

7. When, in your estimation, will this employee be ready to return to full duty? Date: _____

8. Comments: _____

Physician's Signature _____	Telephone Number () _____	Date _____
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ALTERNATE DUTY PROGRAM

New York State and the Public Employees Federation AFL-CIO, (PEF), negotiated an Alternate 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 Professional, Scientific & Technical Services Unit, 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) and the employee is within 45 days of full recovery, he/she is qualified for an alternate duty assignment. The agency will use the information provided on this form to design an assignment that is consistent with the employee's limitations and capabilities. An assignment will be given to an employee initially for no more than 45 days. Agencies can extend assignments on a discretionary basis until the employee has fully recovered and returns to his/her regular assignment.

During the period of alternate 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 alternate duty assignment should be directed to the employee's agency.