ESTIMATED FUNCTIONAL CAPACITY EVALUATION
To be completed by treating physician.

Patient:

Definitions for your reference:

SEDENTARY WORK: lift 10# maximum and occasionally carry small objects
LIGHT WORK: lift 20# maximum; frequently lift/carry up to 10#
MEDIUM WORK: lift 50# maximum; frequently lift/carry up to 25#
HEAVY WORK: lift 100# maximum; frequently lift/carry up to 50#
VERY HEAVY WORK: lift in excess of 100#; frequently lift/carry 50#

I WOULD ESTIMATE THIS PERSON TO BE ABLE TO:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Occasionally (1-33%)</th>
<th>Frequently (34-66%)</th>
<th>Continuously (67-100%)</th>
</tr>
</thead>
</table>

1. LIFT:
   a. up to 10#
   b. 11 - 24#
   c. 25 - 34#
   d. 35 - 50#
   e. 51 - 74#
   f. 75 - 100#

2. CARRY:
   a. up to 10#
   b. 11 - 24#
   c. 25 - 34#
   d. 35 - 50#
   e. 51 - 74#
   f. 75 - 100#

3. PERFORM THE FOLLOWING TASKS:
   - Push/Pull – Seated
   - Push/Pull – Standing
   - Bend
   - Squat
   - Crawl
   - Climb
   - Reach above shoulder level

4. ASSUMING AN 8-HOUR WORKDAY WITH TWO 15-MINUTE BREAKS AND AN HOUR MEAL BREAK, I WOULD EXPECT THIS PERSON TO BE ABLE TO:

   Circle number of hours for each activity. NOTE: Total does not have to equal 8 hours.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of Hours</th>
<th>Continuously</th>
<th>With Rests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sit</td>
<td>1 2 3 4 5 6 7 8</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Stand</td>
<td>1 2 3 4 5 6 7 8</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Walk</td>
<td>1 2 3 4 5 6 7 8</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Alternately Sit/Stand</td>
<td>1 2 3 4 5 6 7 8</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
5. CAN PERSON USE HANDS FOR REPETITIVE ACTIONS SUCH AS:

<table>
<thead>
<tr>
<th></th>
<th>Simple Grasping</th>
<th>Firm Grasping</th>
<th>Fine Manipulating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right:</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Left:</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

Estimated Grip Strength: Right: # Left: #

6. CAN PERSON USE FEET FOR REPETITIVE MOVEMENTS AS IN OPERATING FOOT CONTROLS?

<table>
<thead>
<tr>
<th></th>
<th>Right (Alone)</th>
<th>Left (Alone)</th>
<th>Both (Simultaneously)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

7. ANY RESTRICTIONS OF ACTIVITIES INVOLVED?

<table>
<thead>
<tr>
<th>Activity</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unprotected Heights</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Being around moving machinery</td>
<td></td>
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<tr>
<td>Exposure to marked changes in temperature and humidity</td>
<td></td>
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<tr>
<td>Driving automotive equipment</td>
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<tr>
<td>Exposure to dust; fumes; gases</td>
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</tr>
</tbody>
</table>

8. CAN PERSON CONTINUE IN CURRENT JOB? Yes ☐ No ☐

   If not, can person return to other work according to restrictions defined above? Yes ☐ No ☐

   Can the person work full-time? Yes ☐ No ☐

   If not, can the person work part-time? Yes ☐ No ☐

   If person can work part-time but not full-time, please estimate schedule, in hours per day and days per week:

   Disability rating (if applicable):  %

9. COMMENTS:

   Physician Name: 

   Address: 

   City, State, Zip: 

   Telephone:     Field of Specialty:    License No.: 

   Signature:     Date: 

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