



INSTRUCTIONS:

- Complete the items below on your clinical evaluation and other testing results of the injured worker per an eight-hour workday.
Check appropriate boxes as you complete this form.

Form with fields: Injured worker name, Claim number, Social Security number if claim number unknown, Date of injury, Injured worker occupation, Employer name

Work/Non-work capabilities

Table with columns: % of workday (8 hours) Repetitions per hour, None at all 0%, Occasional 1%-33% 4-6, Frequent 34%-66% 6-12, Continuous 67%-100% >12. Rows include Lift/carry, Bending, Twist/turn, Reach below knee, Push/pull, Squat/kneel, Stand/walk, Sit, Lifting above shoulders.

WORK ACTIVITY

Hand restrictions: Left, Right, Must wear splint, No lifting greater than ___ lbs, No repetitive activities, No work with hot or cold substances. No use of: Left, Right, Arm, Hand, Finger, Other.

Are the restrictions temporary or permanent? If temporary, give an opinion as to the expected duration of the restrictions: from ___ to ___. Due to the restrictions noted above, how many total hours per day and per week is the injured worker able to work? ___ Hours ___ Days

Physician's further explanation of work abilities or why the injured worker is unable to perform any work: [Blank lines for text]

I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Physician signature (mandatory)

Date / /