

PART B: Return to Work

2. Is the employee cleared to return to work? No Yes
If so, what is the effective date? _____

3. Is the employee unable to perform any of his/her job functions due to the condition? No Yes
Check if Title Standard was provided:

If so, identify the job functions the employee is unable to perform:

4. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No Yes

If so, are the treatments or the reduced number of hours of work medically necessary? No Yes

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Attach additional information if necessary

Signature of Health Care Provider

Date



ESTIMATED PHYSICAL CAPABILITIES FORM

FOR NYS COURT EMPLOYEES

EMPLOYEE NAME: _____ TITLE: _____ WORK LOCATION: _____

THIS FORM MUST BE COMPLETED BY HEALTH CARE PROVIDER:

INSTRUCTIONS: Provide medical diagnosis including a detailed description of the above-named individual's injury or illness and prognosis for recovery:

Please check appropriate boxes for all questions below.

1. In an eight-hour workday, how many hours can this employee:

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

2. 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:

	Never	Occasionally	Frequently	Continuously													
LIFT					Upper Extremities:												
00-10 lbs.					Which hand is dominant? <input type="checkbox"/> Right <input type="checkbox"/> Left												
11-20 lbs.					Can this employee perform repetitive actions such as:												
21-50 lbs.					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 20%;">Simple Grasping</td> <td style="width: 20%;">Pushing & Pulling</td> <td style="width: 20%;">Fine Manipulation</td> </tr> <tr> <td style="text-align: center;">RIGHT</td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td style="text-align: center;">LEFT</td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> </table>		Simple Grasping	Pushing & Pulling	Fine Manipulation	RIGHT	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	LEFT	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Simple Grasping	Pushing & Pulling	Fine Manipulation														
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LEFT	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N														
51-100 lbs.																	
CARRY					Lower Extremities:												
00-10 lbs.					Use of feet/legs for repetitive movement, as in operation of foot controls or motor vehicles.												
11-20 lbs.					<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"></td> <td style="width: 33%;">RIGHT</td> <td style="width: 33%;">LEFT</td> <td style="width: 33%;">SIMULTANEOUS</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td></td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> <td style="text-align: center;"><input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> </table>		RIGHT	LEFT	SIMULTANEOUS		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
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21-50 lbs.																	
51-100 lbs.																	
BEND					Does this employee have any visual or hearing impairment requiring accommodation? If yes, explain. <input type="checkbox"/> Y <input type="checkbox"/> N												
SQUAT																	
CLIMB					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 employee returning to work? If yes, please explain. <input type="checkbox"/> Y <input type="checkbox"/> N												
RUN																	
Reach above shoulder level																	
Operate a motor vehicle					Can this employee operate moving machinery? <input type="checkbox"/> Y <input type="checkbox"/> N												

When, in your estimation, will this employee be ready to return to work? Date: ____ / ____ / ____

HEALTH CARE PROVIDER (PRINT NAME): _____ TELEPHONE: _____

TYPE OF PRACTICE/MEDICAL SPECIALTY: _____

HEALTH CARE PROVIDER'S SIGNATURE: _____ DATE: ____ / ____ / ____