

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	Upper Extremities:		
LIFT					Which hand is dominant? <input type="checkbox"/> Right <input type="checkbox"/> Left		
00-10 lbs.					Can this employee perform repetitive actions such as:		
11-20 lbs.						Simple Grasping	Pushing & Pulling
21-50 lbs.					RIGHT	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
51-100 lbs.					LEFT	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
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.						RIGHT	LEFT
21-50 lbs.						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
51-100 lbs.						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
BEND						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
SQUAT					Does this employee have any visual or hearing impairment requiring accommodation? If yes, explain.		<input type="checkbox"/> Y <input type="checkbox"/> N
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.		
RUN					<input type="checkbox"/> Y <input type="checkbox"/> N		
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: ____/____/____



DUTIES ASSESSMENT FORM FOR COURT OFFICERS

(REVISED 1/14)

EMPLOYEE NAME: _____ RANK: _____

WORK LOCATION: _____

*****BELOW MUST BE COMPLETED BY HEALTH CARE PROVIDER*****

DATE OF INJURY OR ILLNESS: _____

PROVIDE MEDICAL DIAGNOSIS and detailed description of the above named individual's injury or illness and prognosis for recovery:

Based upon your medical diagnosis, indicate which duties *may* or *may not* be performed:

- | | | |
|------------------------------|----------------------------------|---|
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Provide security by standing in courtroom and patrolling courthouse vicinity (includes navigating stairs). |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Guard criminal defendants while in courtroom and escort to and from detention cells. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Physically restrain unruly or combative individuals. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Arrest individuals according to established procedures. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Escort and protect judges, juries and witnesses to and from the courtroom. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Use established search procedures to assure that no weapons or prohibited electronic equipment are brought into the courtroom. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Search courtrooms and other areas of a court facility for contraband (search areas include under benches, tables and suspended ceilings). |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Provide general information to visitors on court premises. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Check to insure that all necessary documents are available prior to court session. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Display and safeguard exhibits in the courtroom. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Maintain and update court records, and prepare incident reports. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Distribute and post appropriate documents and court records. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Provide assistance in emergency situations (and administer first aid). |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Wear required uniform. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Carry (posses and retain) a service firearm. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Carry other equipment including handcuffs, baton & pepper spray (and wear duty rig). |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Wear body armor/bullet proof vest. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Travel to various court locations. |
| Attend training: | | |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | Firearms re-certification. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | CPR re-certification. |
| <input type="checkbox"/> May | <input type="checkbox"/> May Not | OC(pepper spray)/baton/handcuffing training. |

Is the individual taking any medications that will affect his/her ability to perform the job duties of a court officer?

☐ Yes ☐ No

If yes, please explain: _____

HEALTH CARE PROVIDER (NAME): _____ TELEPHONE: _____

TYPE OF PRACTICE/MEDICAL SPECIALTY: _____

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