**Work Ability Report**

**To Be Completed by the Treating Physician**

**Claimant: Last 4 SSN/ID: Employer: Date of Injury: Payer: Claim Number:**

**Based on my assessment and treatment of this injury, I recommend:**

 **Can the employee work an 8-hour day?** Yes No If no, how many hours / day?

 **In an 8-hour day, employee can:** (circle full capacity for each)

Sit 1 2 3 4 5 6 7 8 Hours / Day Stand 1 2 3 4 5 6 7 8 Hours / Day Walk 1 2 3 4 5 6 7 8 Hours / Day

 **Employee can lift / carry:** (please check as appropriate)

Not at this time Occasionally Frequently No

Restriction

Lift Carry Lift Carry Lift Carry Lift

Carry

0-10 lb.

11-25 lb.

26-50 lb.

51-100 lb.

100+

 **Employee is able to:** (please check all that apply)

Not at this time Occasionally Frequently Constantly

No Restriction

0% 1-33% 34-66% 67-100%

Balance Bend Climb Crawl Squat Kneel Reach Twist

Use Foot

R L

 **Employee is able to operate:** (check as appropriate

Not at this time Occasionally Frequently No Restriction

Car

Small truck

Large truck

Automatic transmission

Standard transmission

Heavy equipment



**Employee can use upper extremities for repetitive:** (check as appropriate)

Simple Grasp Firm Grasp Fine Manipulation Pushing / Pulling (Circle Appropriate) Yes No Yes No Yes No Yes No Right Left

 **Employee can use lower extremities for repetitive movement such as foot controls:**

Right Yes No Left Yes No

**Employee is released to work as of:** / /

With / Without restrictions noted above.

**Date of next evaluation:** / /

**Medical Provider’s Signature:**

Date: / /

**Print Provider’s Name:**