KSU Division of Facilities
Work Capacities Form

Prepared by Dr. _____ Date _____ Patients Name: _____

Please note on this form any restrictions that you feel should be considered in returning this individual to work. This person is in a job with usual work tasks as follows:

☐ Light physical (clerical/administrative)

☐ Moderately Physical (housekeeping/maintenance)

☐ Other _____

☐ Heavy physical labor (construction)

☐ OTR Trucker/Driver
Heavy equipment operator

Lift /Carry/Push/Pull/Grasp - Right Hand Weight Limit _____

Lift/Carry/Push/Pull/Grasp - Left Hand Weight Limit _____

	Continuous	Frequent	Occasional	Never
Sit:	_____	_____	_____	____
Walk:	_____	_____	_____	_____
Stand:	_____	_____	_____	_____
Bend:	_____	_____	_____	_____
Squat:	_____	_____	_____	_____
Crawl:	_____	_____	_____	_____
Climb (describe)	_____	_____	_____	_____
Reach above shoulders:	_____	_____	_____	_____

_____
Physician Signature

_____
Date / Time

_____
Next Appointment

Is the patient restricted by environmental factors (i.e. dampness, heat or cold, height, exposure to dust, gasses, fumes, etc.)?
Comments:

Is patient involved with treatment and/or medications that might affect ability to work?
___ no ___ yes (describe)

Can patient operate a motor vehicle? _____ car _____ truck

How many hours can patient work? _____ hours in a day _____ days in a week

Maximum medical improvement? ____ yes ___ no (please indicated anticipated date) _____

Comments: