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				
00-10 lbs.				
11-20 lbs.				
21-50 lbs.				
51-100 lbs.				
CARRY				
00-10 lbs.				
11-20 lbs.				
21-50 lbs.				
51-100 lbs.				
BEND				
SQUAT				
CLIMB				
RUN				
Reach above shoulder level				
Operate a motor vechicle				

Upper Extremities:

Which hand is dominant?	□ Right	□ Left

Can this employee perform repetitive actions such as:

	Simple Grasping	Pushing & Pulling	Fine Manipulation
RIGHT	□ Y □ N	□ Y □ N	□ Y □ N
LEFT	□ Y □ N	□ Y □ N	□ Y □ N

Lower Extremities:

Use of feet/legs for repetitive movement, as in operation of foot controls or motor vehicles.

	RIGHT	LEFT	SIMULTANEOUS
	□ Y □ N	□ Y □ N	□ Y □ N
	□ Y □ N	□ Y □ N	□ Y □ N

Does this employee have any visual or hearing impairment requiring accommodation? If yes, explain.	□ Y □ N
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.	□ Y □ N
Can this employee operate moving machinery?	□ Y □ 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: _____/_____/_____

Revised 7/2012