S.A.F.E. Group

PHYSICAL CAPABILITIES ANALYSIS

Patient: _____ **Date of examination:** _____

Work related injury / illness: [ ] Yes [ ] No **Physician [ ] Physio [ ] Chiropractor [ ]**

Name: _____ **Other Medical Practitioner** _____
(please print) (please specify)

Address:_____ **Signature:**_____

Invoices may be submitted to the individual's company for work-related injuries only at a rate of $15.00 / completed form.

Subject to the capabilities listed below, our Company can accommodate light / modified / alternate duties. Completion of this form will enable us to facilitate this individual's earliest return to work. Please return this form completed with the individual after your examination or fax it directly to the individual's company listed below, immediately following the examination.

A: THIS PERSON IS *CAPABLE* OF:			***NOT APPLICABLE. SEE COMMENTS.***		
1	Balance	Yes / No	12	Lifting up to 25 lbs.	Yes / No
2	Crawling	Yes / No	13	Lifting up to 50 lbs.	Yes / No
3	Crouching	Yes / No	14	Pushing up to _____ lbs.	Yes / No
4	Climbing Ladders	Yes / No	15	Pulling up to _____ lbs.	Yes / No
5	Climbing Stairs	Yes / No	16	Reaching	Yes / No
6	Kneeling	Yes / No	17	Raising right arm above shoulder	Yes / No
7	Stooping / Bending	Yes / No	18	Raising left arm above shoulder	Yes / No
8	Standing _____%	Yes / No	19	Tactile sensation - Indicate extremities	Yes / No
9	Walking _____%	Yes / No	20	Use of both hands - see section B	Yes / No
10	Sitting _____%	Yes / No	21	Operating heavy equipment (forklift, crane)	Yes / No
11	Lifting up to 10 lbs.	Yes / No	22	Operating motor vehicle / transport vehicle	Yes / No

B: THIS PERSON IS *LIMITED* TO:		
1	Use of right hand, partial use of left	
2	Use of left hand, partial use of right	
3	Use of right hand only	
4	Use of left hand only	

C: THIS PERSON *SHOULD NOT* BE EXPOSED TO:		
1	Heat / Cold	
2	Vibration / Excessive Noise	
3	High places	
4	Mechanical hazards / Moving machinery	
5	Chemical Exposure / Allergies	

Is the individual involved with medication that might affect his/her ability to work? [ ] Yes [ ] No

Based on the above capabilities, is the individual capable of performing light or modified duties effective immediately?
[ ] Yes [ ] No Duration of light or modified duties? _____

If no, when will the individual be able to return to work?
Modified duties _____ Regular duties _____

Are all limitations considered permanent? [ ] Yes [ ] No

Is the individual capable of working his/her regular work day with modified duties? [ ] Yes [ ] No

Comments:

Please fax to:

[ ]	Company Name, Contact Person	Fax No.	[ ]	Company Name, Contact Person	Fax No.
[ ]	Company Name, Contact Person	Fax No.	[ ]	Company Name, Contact Person	Fax No.
[ ]	Company Name, Contact Person	Fax No.	[ ]	Company Name, Contact Person	Fax No.
[ ]	Company Name, Contact Person	Fax No.	[ ]	Company Name, Contact Person	Fax No.

AUTHORIZATION TO RELEASE INFORMATION

I am aware that alternate/modified duties are available in my workplace, and hereby authorize my attending physician /physio/chiropractor _____(Name) to release my functional (work) abilities to my employer. I understand that all information, discussions and reports will be held in the strictest confidence.

_____ _____
Employee signature Date