MEMIC
Partners for Workplace Safety™

PHYSICAL ASSESSMENT EVALUATION FORM

An important aspect of (employer/company name)is Return-to-Work Program is returning an injured employee to work as soon as possible after the date of injury. Please provide the following information so that we can best determine the physical limitations of the worker and, if necessary, place the employee in a suitable, temporary modified job. (Circle one of the following):

1. **Work Related** **Non-Work Related** - **Shift Worked: 7-3 3-11 11-7 Other**

Name of Employee	Date of Examination	Date of Next Appointment
Employee Social Security Number	Company Address	Company Phone Number

2. **Medication:** Please list any medication prescribed for use during working hours that would affect alertness or ability to respond to an emergency:

3. **Referred to Dr.**_____ Date_____ Time_____
Lab____ x-ray____ Physical Therapy____ Occupational Therapy____ Other_____

4. **Diagnosis:**_____

5. **Physician Comments:**_____

6. **Patientís Instructions:**_____

7. **Work Ability:** **No Restrictions**____ **Modified Work As Indicated Below**____ **Unable to Work Until**_____
Employee can work_____ hours per day.

   In a workday the employee can____ for increments of up to_____ hours. (Circle applicable functions and hours restricted, if any, or check if no restrictions apply.)

a. Sit	0,	1,	2,	3,	4,	5,	6,	7,	8,	___No Restrictions
b. Stand	0,	1,	2,	3,	4,	5,	6,	7,	8,	___No Restrictions
c. Walk	0,	1,	2,	3,	4,	5,	6,	7,	8,	___No Restrictions
d. Inside	0,	1,	2,	3,	4,	5,	6,	7,	8,	___No Restrictions
e. Outside	0,	1,	2,	3,	4,	5,	6,	7,	8,	___No Restrictions

   Note: In terms of an 8 hour workday iOccasionallyî equals 1% to 33%, iFrequentlyî equals 34% to 66% and iContinuouslyî equals 67% to 100%. (Circle applicable functions and check time limitations, if any, or check if no restrictions apply.)

a. **Employee can lift:**

	Never	Occas.	Freq.	Cont.	No Restrictions
Up to 10 lbs.					
11 – 24 lbs.					
25 – 34 lbs.					
35 – 50 lbs.					
51 – 74 lbs.					
75 – 100 lbs.					

b. **Employee can carry (lift and transport) an object 10 feet or more:**

	Never	Occas.	Freq.	Cont.	No Restrictions
Up to 10 lbs.					
11 – 24 lbs.					
25 – 34 lbs.					
35 – 50 lbs.					
51 – 74 lbs.					
75 – 100 lbs.					

c. **Employee is able to:**

	Never	Occas.	Freq.	Cont.	No Restrictions
Bend					
Crouch					
Squat					
Push/Pull					
Crawl					
Climb Stairs					
Climb Ladders					
Reach Above Shoulder level					
Lift Above Shoulder level					
Balance					
Work on Uneven Ground					
Kneel					
Other					

Comments: (if applicable, note frequency per hour per day)

d. **Employee can use head and neck in:**

	Never	Occas.	Freq.	Cont.	No Restrictions
Static Position					
Frequent Flexing					
Frequent Rotating					

e. **Employee can use hands for repetitive actions such as:**

		Never	Occas.	Freq.	Cont.	No Restrictions
Simple Grasping	Rt.					
	Lt.					
Firm Grasping	Rt.					
	Lt.					
Fine Manipulating						
(pinch gripping)	Rt.					
	Lt.					

f. **Employee can use foot operated controls:**

	Never	Occas.	Freq.	Cont.	No Restrictions
Right					
Left					

g. **Other (e.g. hearing or vision loss).**

I authorize the release of information concerning my present illness/injury to my employer and their workersí compensation insurance carrier.

Employee Signature **Date**

Printed Physician Name, Address & Phone Number **Physician Signature**