PHYSICIAN'S EVALUATION

Name_______________________ Soc. Security #____________ Date of Injury ______

Address____

Date of Birth_______ Occupation ______________________ Date of First Visit_______

Employer Name & Address____

History of Injury:____

Diagnosis:____

Recommendations for Work:

______ Regular Work ______ Modified Work ____ No Work

Full Time	Part Time	
_____	_____	**Sedentary Work**: Lifting 10 pounds maximum and occasionally lifting and/or carrying small articles
_____	_____	**Light Work:** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds.
_____	_____	**Medium Work:** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects up to 25 pounds.
_____	_____	**Heavy Work:** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects up to 50 pounds.
_____	_____	**Very Heavy Work:** Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.

Position Limitations:

	Hrs/Day
Standing	
Reaching above shoulders	
Repetitive wrist motion	
Squatting	
Kneeling	

	Hrs/Day
Sitting	
Reaching below waist	
Exposure to vibrating tools	
Climbing	

Patient Disposition:

______ Off work from ____

______ Return to work no modification, ____________________________

______ Return to work with above modification ____________________

______ No work until ______________ or next office visit ______________

______ Referral to ____

______ Treatment plan____

Comments____

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Physician's Name ______________________ Physician's Signature ____________