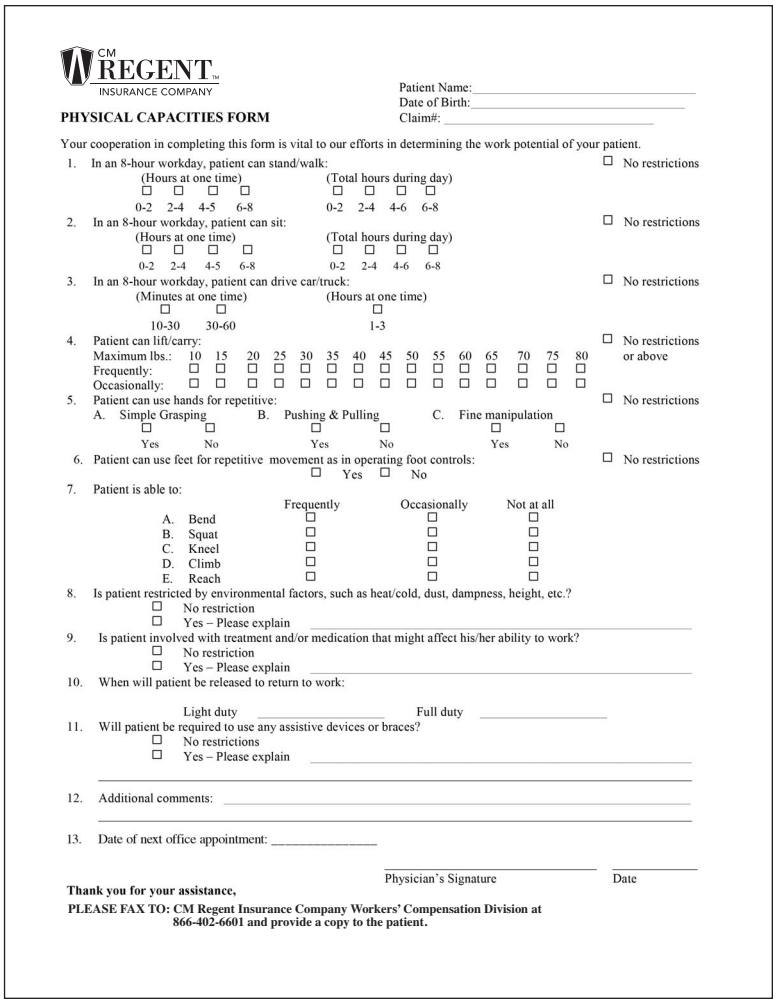
Physical Capacities Form

What Is It: Form completed by treating/panel physician (at time of injury and ongoing throughout course of treatment of work injury) with a detailed breakout of what the current physical abilities are of the injured worker (IW) in order to attempt to allow IW to remain in the workforce.

Importance: Provides immediate update to employer and Claim Representative as to what the IW is able to do with respect to his/her work duties and/or provides assistance to employer in developing transitional duty (if applicable).

How Form Is to Be Used: Upon notification of an injury that requires treatment, provide form to injured worker and to the panel doctor for completion by treating/panel physician.



CM REGENT INSURANCE COMPANY

Patient Name: _____
Date of Birth: _____
Claim#: _____

PHYSICAL CAPACITIES FORM

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.

1. In an 8-hour workday, patient can stand/walk: ☐ No restrictions
   (Hours at one time) ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8 (Total hours during day) ☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8
2. In an 8-hour workday, patient can sit: ☐ No restrictions
   (Hours at one time) ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8 (Total hours during day) ☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8
3. In an 8-hour workday, patient can drive car/truck: ☐ No restrictions
   (Minutes at one time) ☐ 10-30 ☐ 30-60 (Hours at one time) ☐ 1-3
4. Patient can lift/carry: ☐ No restrictions or above

	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80
Maximum lbs.:															
Frequently:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Patient can use hands for repetitive: ☐ No restrictions
   A. Simple Grasping ☐ Yes ☐ No B. Pushing & Pulling ☐ Yes ☐ No C. Fine manipulation ☐ Yes ☐ No
6. Patient can use feet for repetitive movement as in operating foot controls: ☐ Yes ☐ No ☐ No restrictions
7. Patient is able to:

	Frequently	Occasionally	Not at all
A. Bend	☐	☐	☐
B. Squat	☐	☐	☐
C. Kneel	☐	☐	☐
D. Climb	☐	☐	☐
E. Reach	☐	☐	☐

8. Is patient restricted by environmental factors, such as heat/cold, dust, dampness, height, etc.?
   ☐ No restriction
   ☐ Yes – Please explain _____
9. Is patient involved with treatment and/or medication that might affect his/her ability to work?
   ☐ No restriction
   ☐ Yes – Please explain _____
10. When will patient be released to return to work:
    Light duty _____ Full duty _____
11. Will patient be required to use any assistive devices or braces?
    ☐ No restrictions
    ☐ Yes – Please explain _____
12. Additional comments: _____
13. Date of next office appointment: _____

Physician's Signature _____ Date _____

Thank you for your assistance,

PLEASE FAX TO: CM Regent Insurance Company Workers' Compensation Division at 866-402-6601 and provide a copy to the patient.

CM REGENT™ INSURANCE COMPANY

Patient Name:_____
Date of Birth:_____
Claim#: _____

PHYSICAL CAPACITIES FORM

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1. In an 8-hour workday, patient can stand/walk: ☐ No restrictions

(Hours at one time)				(Total hours during day)			
☐	☐	☐	☐	☐	☐	☐	☐
0-2	2-4	4-5	6-8	0-2	2-4	4-6	6-8

2. In an 8-hour workday, patient can sit: ☐ No restrictions

(Hours at one time)				(Total hours during day)			
☐	☐	☐	☐	☐	☐	☐	☐
0-2	2-4	4-5	6-8	0-2	2-4	4-6	6-8

3. In an 8-hour workday, patient can drive car/truck: ☐ No restrictions

(Minutes at one time)		(Hours at one time)
☐	☐	☐
10-30	30-60	1-3

4. Patient can lift/carry: ☐ No restrictions or above

Maximum lbs.:	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80
Frequently:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Patient can use hands for repetitive: ☐ No restrictions

A. Simple Grasping		B. Pushing & Pulling		C. Fine manipulation	
☐	☐	☐	☐	☐	☐
Yes	No	Yes	No	Yes	No

6. Patient can use feet for repetitive movement as in operating foot controls: ☐ No restrictions
   ☐ Yes ☐ No

7. Patient is able to:

	Frequently	Occasionally	Not at all
A. Bend	☐	☐	☐
B. Squat	☐	☐	☐
C. Kneel	☐	☐	☐
D. Climb	☐	☐	☐
E. Reach	☐	☐	☐

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   ☐ No restriction
   ☐ Yes – Please explain _____

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   ☐ No restriction
   ☐ Yes – Please explain _____

10. When will patient be released to return to work:

    Light duty _____ Full duty _____

11. Will patient be required to use any assistive devices or braces?
    ☐ No restrictions
    ☐ Yes – Please explain _____

    _____

12. Additional comments: _____

    _____

13. Date of next office appointment: _____

_____ _____
Physician's Signature Date

Thank you for your assistance,

PLEASE FAX TO: CM Regent Insurance Company Workers' Compensation Division at 866-402-6601 and provide a copy to the patient.