




# 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 Claims 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.



**PHYSICAL CAPACITIES FORM**

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Claim#: \_\_\_\_\_

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) \_\_\_\_\_ (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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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.**

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 Date of Birth: \_\_\_\_\_  
 Claim#: \_\_\_\_\_

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12. Additional comments: \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Physician's Signature

\_\_\_\_\_  
 Date

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