

Work Capacity Evaluation
Musculoskeletal Conditions

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



Injured Worker's Name (First, middle, last)	OWCP No.	OMB No: Expires:	1215-0103 08-31-2005
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Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions:

1a. Is the worker capable of performing his/her usual job? Yes No. If no, please explain.

Many employers can readily accommodate medical restrictions including assignment of the injured worker into an alternative work location.

b. If the claimant is unable to perform his/her usual job, is the claimant able to work for 8 hours per workday with restrictions? Yes No. If no, please provide medical reasons to support your opinion.

c. If less than 8 hours per workday, how many can he/she work?

d. Do you anticipate an increase in the number of hours this person will be able to work? Yes No

e. If yes, when will this person achieve an 8 hour workday? If no, please provide medical reasons to support your opinion

f. How long will the restrictions apply?

g. Has maximum medical improvement been reached? Yes No.

2. Please indicate whether this person has any **LIMITATION** in the activity listed and how many hours this person can perform each activity. If there are limitations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.

Activity	Limitation	# of Hours Able to Work	Activity	Limitation	# of Hours Able to Work	Lbs.
Sitting	___ Yes	_____	Repetitive Movements:			
Walking	___ Yes	_____		Wrists	___ Yes	_____
Standing	___ Yes	_____	Elbow	___ Yes	_____	
Reaching	___ Yes	_____	Pushing	___ Yes	_____	
Reaching above			Pulling	___ Yes	_____	
Shoulder	___ Yes	_____	Lifting	___ Yes	_____	
Twisting	___ Yes	_____	Squatting	___ Yes	_____	
Bending/Stooping	___ Yes	_____	Kneeling	___ Yes	_____	
Operating Motor Vehicle at work	___ Yes	_____	Climbing	___ Yes	_____	
Operating a Motor Vehicle to/from work	___ Yes	_____	Breaks:			
			Duration	_____	Frequency	_____
			Duration	_____	Frequency	_____

3. Are there **OTHER** medical facts, situational factors, equipment or devices which need to be considered in the identification of a position for this person? If so, please explain.

4. Physician's Name (Type or print)	5. Telephone
6. Signature	7. Date

The information requested will assist OWCP in determining eligibility to benefits and is required to obtain or retain a benefit. (5 USC 8101 et. seq.)

Public Burden Statement

We estimate that it will take an average of 15 minutes per response to complete this information collection including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.