

WORK RESTRICTION EVALUATION

2. "X" THE FREQUENCY AND NUMBER OF HOURS A DAY THE WORKER IS ABLE TO DO THE FOLLOWING SPECIFIC TYPES OF ACTIVITIES

ACTIVITY	FREQUENCY		NUMBER OF HOURS A DAY									
	Continuous	Intermittent	0	1	2	3	4	5	6	7	8	
a. Sitting												
b. Walking												
c. Lifting												
d. Bending												
e. Squatting												
f. Climbing												
g. Kneeling												
h. Twisting												
i. Standing												
j. Other (Specify)												

3. LIFTING RESTRICTION (Pounds) ("x" one)
 0-10 10-20 20-50 50-75 75 and over

4. CAN THE WORKER REACH OR WORK ABOVE THE SHOULDER?
 No Yes

5. HAND RESTRICTIONS
 No Yes (complete a, b, and c)

5a. Simple Grasping
 No Yes

5b. Pushing and Pulling
 No Yes

5c. Fine Manipulation
 No Yes

6. CAN THE WORKER USE HIS/HER FEET TO OPERATE FOOT CONTROLS OR FOR REPETITIVE MOVEMENT?
 No Yes

7. CAN THE WORKER OPERATE A CAR, TRUCK, CRANE, TRACTOR, OR OTHER TYPE OF MOTOR-OPERATED EQUIPMENT?
 No Yes

8. ARE THERE CARDIAC, VISUAL, OR HEARING LIMITATIONS?
 No Yes (Describe)

9. ARE THERE RESTRICTIONS CONCERNING HEAT, COLD, DAMPNES, HEIGHT, TEMPERATURE CHANGES, HIGH SPEED WORKING, OR EXPOSURE TO DUST, FUMES, OR GASES?
 No Yes (Describe)

10. ARE INTERPERSONAL RELATIONS EFFECTED BECAUSE OF A NEUROPSYCHIATRIC CONDITION?
 No Yes (Describe ability to give and take supervision, meet deadlines, etc.)

11. CAN THE WORKER WORK EIGHT HOURS A DAY?
 No Yes (Indicate when)

11a. Can the worker work overtime?
 No Yes (Indicate when)

11b. If yes, how many hours and when?

12. DO YOU ANTICIPATE THE WORKER WILL NEED VOCATIONAL REHABILITATION SERVICES SUCH AS TESTING, COUNSELING, TRAINING, OR PLACEMENT TO RETURN TO WORK?
 No Yes

13. HAS THE WORKER REACHED MAXIMUM IMPROVEMENT? (Indicate when)
 No Yes

14. IS THE WORKER PHYSICALLY AND MENTALLY ABLE TO PERFORM THE DUTIES OF HIS/HER GOVERNMENT POSITION? (Job description and performance standards attached)
 No (Explain) Yes

15. WILL THE CONDITION CONTINUE LONGER THAN SIX MONTHS?
 No Yes

16. REMARKS (Restrictions from medication or other limitations. Use reverse side or additional sheets if necessary)

17. NAME AND ADDRESS OF PHYSICIAN

18. SIGNATURE OF PHYSICIAN

19. TELEPHONE NUMBER OF PHYSICIAN

20. DATE SIGNED BY PHYSICIAN

This request for information is authorized by 5 CFR Part 339. Information collected will be used for purposes of employment- related decisions and will be handled and stored in compliance with the Freedom of Information Act and the Privacy Act of 1974. The information requested is voluntary; however, benefits/recommendations may not be considered unless this report is completed and filed as requested.