WORK	(RESTRIC		LUATION	USDA-MR	T. NAME	OF EMPLOYE	= (First, Mid	ale, Lasi	9					
2. "X" THE FREQUENCY AN	D NUMBER OF	HOURS A DAY	THE WORKE	R IS ABLE TO I	DO THE FOLLO	WING SPECI	IC TYPES (OF ACTI	VITI	ES				
	FREQU	UENCY	NUMBER OF HOURS A DAY											
ACTIVITY	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 (P			4. CAN THE	WORKER R	EACH	DR V	VORK ABC	VE THE SH	OULDER?					
	-20	20-50	50-75	75 and o	ver		No			Yes				
5. HAND RESTRICTIONS	5a. Simple Grasping			5b. Pushing and Pulling			5c. Fine Manipulation Yes No Yes							
6. CAN THE WORKER USE	FOOT CONTROLS OR FOR 7. CAN THE V							RUCK, CRANE, TRACTOR, OR OTHER						
8. ARE THERE CARDIAC, VI		No RING LIMITATI	Ves ONS?		TYPE OF MO	IOR-OPERAT	ED EQUIPM	ENT?		No	Ye	S		
No		Yes (Describe)												
9. ARE THERE RESTRICTIONS O	CONCERNING HE	AT, COLD, DAMP	NESS, HEIGHT, 1	TEMPERATURE C	HANGES, HIGH	SPEED WORKIN	G, OR EXPOS	SURE TO	DUS	ST, FUMES, O	OR GASES?			
No		Yes (Describe)												
10. ARE INTERPERSONAL F	RELATIONS EF	FECTED BECA	USE OF A NEU	IROPSYCHIATI	RIC CONDITIO	N?								
No			ability to give ar eet deadlines, e											
11. CAN THE WORKER WORK EIGHT HOURS A DAY? 11a. Can the worker No Yes (Indicate when)					rtime? 11b. If yes, how many hours and when? e when)									
12. DO YOU ANTICIPATE TH SUCH AS TESTING, COUNS	ABILITATION S	ERVICES												
	K:													
14. IS THE WORKER PHYSICALLY AND MENTALLY ABLE TO PERFORM THE DUTIES C (Job description and performance standards attached)						F HIS/HER GOVERNMENT POSITION?				15. WILL THE CONDITION CONTINUE LONGER THAN SIX MONTHS?				
No (Explain)														
16. REMARKS (Restrictions f	rom medication	or other limitati	ons. Use rever	se side or addit	ional sheets if r	ecessary)								
17. NAME AND ADDRESS O			18. SIGNATU	8. SIGNATURE OF PHYSICIAN										
					19. TELEPHONE NUMBER OF PHYSICIAN			20	20. DATE SIGNED BY PHYSICIAN					
This request for information is compliance with the Freedom unless this report is completed	of Information A	Act and the Priva												