WORK RELEASE / PHYSICAL CAPACITIES

Re: ________________________________              Date of Injury: __________________________

The above worker may return to:
  Regular work on: ______________________
  or
  Modified work on: ____________________
  or
  Not released, anticipated release date: __________________

If modified work, please complete entire form

Is worker capable of full time? ___Yes  ____No
If unable to work full time, specify hours per day ____________

Please indicate which level of modified work the worker is capable of performing:

**Sedentary work:** Lifting 10 pounds maximum. Includes occasionally lifting and/or carrying small objects. Involves sitting; a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking, standing is required only occasionally and all other sedentary criteria are met.

**Light work:** Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds; or requires walking or standing to a significant degree; or requires sitting most of the time but entails pushing and pulling of arm and/or leg controls.

**Light/medium work:** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 15-20 pounds; or requires walking or standing to a significant degree; or requires sitting most of the time but entails pushing of arm and/or leg controls.

**Medium work:** Lifting 50 pounds maximum with frequent lifting and carrying of objects.

**Heavy work:** Lifting 100 pounds maximum with frequent lifting and carrying of objects weighing up to 50 pounds.

**Other specific restrictions: Check any that apply.**
___climbing  ___ kneeling  ___ bending  ___ stooping  ___ repetitive motion  ___ reaching
___grasping  ___ overhead work  ___ twisting  ___ dry environment  ___ other

The modified work restrictions are: ___Permanent  ___Temporary; expected to last _____weeks.

Next appointment date: __________________

_____________________________________          ________________
Physician’s signature      Date