Town of Manchester, Connecticut
Work Capacity Form

Please review the attached job description of the employee when determining restrictions.

Name_____Today's Date_____

Injury Date _____ Surgery Date_____ Work Related ☐ Yes ☐ No

Diagnosis _____

Patient ☐ may return to work without restrictions on _____
date

☐ may return to work with the restrictions listed below on _____
date

☐ may not return to work

☐ Continue work on previous restrictions

Specific Restrictions (if applicable): Restrictions relate to the following body part _____.

	Never	1-2 hrs	2-4 hrs	4-6 hrs	6-8hrs
Lift / Carry	☐	☐	☐	☐	☐
Overhead Lift / Reach	☐	☐	☐	☐	☐
Push / Pull	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Drive (work related)	☐	☐	☐	☐	☐
Bend	☐	☐	☐	☐	☐
Squat	☐	☐	☐	☐	☐
Twist	☐	☐	☐	☐	☐
Climb	☐	☐	☐	☐	☐

Maximum Lifting _____ lbs. Maximum Carry _____ lbs.

Hand Restrictions

☐ Right
☐ Left
☐ Both

☐ Avoid repetitive grasping / pinching
☐ Avoid pushing / pulling
☐ Avoid fine manipulation

Foot Restrictions

☐ Right
☐ Left
☐ Both

Work Related Driving (if applicable)

Patient may drive:

- ☐ Automobile
- ☐ Pickup truck
- ☐ CDL vehicle (commercial driver's license required)
- ☐ Work-related driving not allowed until this date: _____

May drive for: _____ 1-2 hours _____ 2-4 hours _____4-6 hours _____ 6-8 hours _____ full day

OVER

Other:

☐ No work at or above shoulder level

☐ Avoid repetitive use of _____

☐ Further treatment is needed: _____

☐ Follow up appointment: Scheduled for _____

☐ Expected date the employee can return to full duty_____

Additional Comments:

_____

_____

_____

☐ Scheduled appointments for: ☐Bone scan on _____ ☐CTSCAN on _____ ☐ EMG on _____

☐ Blood Tests on _____ ☐ MRI on _____ ☐ Surgery on _____ ☐Therapy on _____

☐X rays taken on _____

Additional Comments Continued: _____

_____

_____

I have read, understood, and received a copy of my instructions. I understand that the above restrictions also apply to other jobs in which I am employed and hobbies, sports, or recreational activities.

_____

Patient Signature Date

_____

Physician Signature Date

Physician Name, Address & Phone & Fax Number:

_____

_____

_____

_____