RELEASE OF INFORMATION

I, _____, hereby authorize _____, physician/
(Please PRINT) (Please PRINT)
practitioner, to furnish written information to _____,
my employer, regarding my residual functional capacity, any limitations or restrictions on my ability to perform the functions of my position and any devices, equipment, or accommodations I require to enable me to perform these functions.

Employee's Signature _____ Date _____

FUNCTIONAL CAPACITY ASSESSMENT

Physician/Practitioner - Please confine your completion of this form to only those elements that are pertinent to the employee's ability to perform the essential functions of his/her job. Explain any limitations in Section G.

Genetic Information Nondiscrimination Act of 2008 Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

A. **POSTURAL LIMITATIONS:**

	Continuously (4-6 hrs./day)	Frequently (2-6 hrs./day)	Infrequently (0-2 hrs./day)	Never
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Reaching	☐	☐	☐	☐
Squatting/Stooping	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐

B. **PHYSICAL EXERTION LIMITATIONS:**

	Up to 10 lbs.	10 lbs. to 25 lbs.	25 lbs. to 50 lbs.	Over 50 lbs.
Lifting	☐	☐	☐	☐
Carrying	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐

C. **MANIPULATIVE LIMITATIONS:**

	Unlimited	Limited
Handling (gross)	☐	☐
Fingering (fine)	☐	☐
Feeling (skin receptors)	☐	☐

D. **MENTAL LIMITATIONS:**

	Unlimited	Limited
Understanding	☐	☐
Remembering	☐	☐
Sustained concentration	☐	☐
Following through on instructions	☐	☐
Decision making	☐	☐
Responding appropriately to workplace pressures	☐	☐
Receiving supervision	☐	☐
Relating to co-workers	☐	☐

E. **VISUAL/COMMUNICATIVE LIMITATIONS:**

	Unlimited	Limited
Acuity (near/far); Depth; Color; Field	☐	☐
Hearing	☐	☐
Speaking	☐	☐

F. **NON-PHYSICAL EXERTION LIMITATIONS:**

Pain (frequency; degree; objective signs)

Environmental restrictions (exposure to dust, fumes, smoke, heights, heat/cold, noise; other)

Rest periods (frequency/duration)

Side effects of medication

G. **REMARKS:**

(Please use this space to explain or clarify any of the preceding information.) Describe any specific limitations or restrictions for any of the above categories and list any assistive devices, equipment, or accommodation the employee requires to perform his or her job:

_____	_____
Physician's/Practitioner's Signature	Date
_____	_____
Name of Practice	Type of Practice
_____	_____
Address	Telephone