Functional Capacity Evaluation

Patient's Name: _____ Today's Date: ___/ ____/_____

Address:_____ Patient's Phone Number: _____

_____

Physician/Practitioner – The aforenamed patient has provided below written authorization to disclose medical information pertinent to their ability to perform the work-related requirements, essential and ancillary job duties of the position they hold, including any limitations or restrictions to perform the functions, any devices, equipment, or accommodations required to enable to perform these functions and any estimated length of incapacity or date for re-evaluation. Please confine your completion of this form to only those elements relevant to the duties and requirements of the position.

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 explicitly allowed by this law. To comply with this law, we request 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.

Employee Authorization for the Release of Medical Information

I,_____, hereby authorize _____ to furnish written
Printed Employee Name Health Care Provider
confirmation to my employer, _____,
Agency Name, Agency Representative Name, and Title

regarding my functional capacity to perform the work-related requirements, essential and ancillary functions of my job duties, including any limitations or restrictions on my ability to perform the functions of my position, any devices, equipment, or accommodations I require to enable me to perform these functions and any estimated length of incapacity or date for re-evaluation.

Employee's Signature:_____ Date: _____

Employee's Printed Name:_____ Date: _____

Functional Capacity Evaluation Continued

Section 1. Work-Related Requirements, Essential Functions, and Ancillary Job Duties [Completed by Agency Representative - Attach additional page(s) as needed]:

Additional Comments:

Functional Capacity Evaluation Continued

Section 2. What is the patient's ability to perform the following functions? [Completed by the evaluating Physician/Practitioner]

Functional Impairment Scale - Frequency	Never	Infrequently 0-2 Hrs. Day	Frequently 3-5 Hrs. Day	Continuously 6-8 Hrs. Day	Unable to Determine/Comments
POSTURAL LIMITATIONS:					
Sitting					
Standing					
Walking					
Bending/Stooping					
Climbing					
Reaching					
Squatting					
Crawling					
Kneeling					
Functional Impairment Scale - Ability	**Up to 10 lbs.**	**10 lbs. to 25 lbs.**	**25 lbs. to 50 lbs.**	**Over 50 lbs.**	**Unable to Determine/Comments**
PHYSICAL EXERTION LIMITATIONS:					
Lifting					
Carrying					
Pushing/Pulling					
Functional Impairment Scale - Ability	**Severely Limited**	**Moderately Limited**	**Mildly Limited**	**Not Limited**	**Unable to Determine/Comments**
MANIPULATIVE LIMITATIONS:					
Handling (gross)					
Feeling (skin receptors)					
Fingering (fine)					

Functional Capacity Evaluation Continued

Functional Impairment Scale - Ability	Severely Limited	Moderately Limited	Mildly Limited	Not Limited	Unable to Determine/Comments
MENTAL LIMITATIONS:					
Understand and Remember Instructions					
Learn and Retain New Information					
Organize Complex Information or Multiple Tasks					
Exhibit Sustained Concentration					
Remember and Follow Through on Tasks					
Exhibit Good Judgement and independent Decision Making					
Respond Appropriately to Workplace Pressures					
Delay Responses When Appropriate					
Respond Appropriately to Change					
Understand and Adhere to Workplace Rules, Policies, and Procedures					
Attend Work Regularly and Adhere to Work Schedule					
Maintain Appropriate Workplace Relationships, Speech, and Actions					
Receiving Supervision and Feedback					
Functional Impairment Scale - Ability	**Severely Limited**	**Moderately Limited**	**Mildly Limited**	**Not Limited**	**Unable to Determine/Comments**
VISUAL/COMMUNICATIVE LIMITATIONS:					
Acuity (near/far); Depth; Color; Field					
Hearing					
Speaking					
Functional Impairment Scale - Ability	**Severely Limited**	**Moderately Limited**	**Mildly Limited**	**Not Limited**	**Unable to Determine/Comments**
NON-PHYSICAL EXERTION LIMITATIONS:					
Work-Related Environmental Requirements (Exposure to dust, fumes, smoke, heights, heat/cold, noise, and other)					

Functional Capacity Evaluation Continued

Functional Impairment Scale	Severely	Moderately	Mildly	None	Unable to Determine/Comments
Effect Medical Treatment or Medication Side Effects Limit Performance					

Please provide any additional information relevant to the patient's ability to perform the work-related requirements, essential and ancillary job duties, including any limitations or restrictions to perform the functions, any devices, equipment, or accommodations required to enable him/her to perform these functions and any estimated length of incapacity or date for re-evaluation if applicable.

This evaluation is based on my examination of the patient on _____.
[Date]

The patient may return to work full duty without restrictions on _____.
[Date]

The patient may return to work with the restrictions noted above on _____.
[Date]

Physician/Practitioner Print Name:_____

Physician/Practitioner Signature: _____ Date: _____