

ESTIMATED PHYSICAL CAPABILITIES FORM FOR NEW YORK STATE EMPLOYEES

Name of Physician: _____

Name of Employee: _____

Note: Important Information on Reverse

Instructions: If the employee is found to be 50% or less disabled, please complete this form based on your estimation of his/her physical capabilities.

1. Medical Diagnosis: _____

2 a. In an eight hour workday, how many hours can this employee: (please check appropriate boxes)

| | | | | | | | | | | |
|-------|---|---|---|---|---|---|---|---|--------------|------------|
| Sit | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | Continuously | With Rests |
| Stand | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | Continuously | With Rests |
| Walk | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | Continuously | With Rests |

b. In a given day, for how many hours can this employee sit, stand, and/or walk in combination?

4 6 8 10 12 14 16

3. Other Capabilities: (please check appropriate boxes)

| | Never | Occasionally | Frequently | Continuously | | | | | | | | | | |
|----------------------------|-------------------|-------------------|------------|--------------|--|-----------------|-------------------|-------------------|-----------|-----------|-----------|-----------|-----------|-----------|
| Lift | | | | | Upper Extremities: Which hand is dominant? Right Left Can this employee perform repetitive actions such as: | | | | | | | | | |
| 0-10 lbs | | | | | | | | | | | | | | |
| 11-20 lbs | | | | | | | | | | | | | | |
| 21-50 lbs | | | | | | | | | | | | | | |
| 51-100 lbs | | | | | | | | | | | | | | |
| Carry | | | | | Right Left <table border="1"> <thead> <tr> <th>Simple Grasping</th> <th>Pushing & Pulling</th> <th>Fine Manipulation</th> </tr> </thead> <tbody> <tr> <td>Yes No</td> <td>Yes No</td> <td>Yes No</td> </tr> <tr> <td>Yes No</td> <td>Yes No</td> <td>Yes No</td> </tr> </tbody> </table> | Simple Grasping | Pushing & Pulling | Fine Manipulation | Yes No | Yes No | Yes No | Yes No | Yes No | Yes No |
| Simple Grasping | Pushing & Pulling | Fine Manipulation | | | | | | | | | | | | |
| Yes No | Yes No | Yes No | | | | | | | | | | | | |
| Yes No | Yes No | Yes No | | | | | | | | | | | | |
| 0-10 lbs | | | | | | | | | | | | | | |
| 11-20 lbs | | | | | | | | | | | | | | |
| 21-50 lbs | | | | | | | | | | | | | | |
| 51-100 lbs | | | | | | | | | | | | | | |
| Bend | | | | | Lower Extremities: Use of feet/legs for repetitive movement as in operation of foot controls and motor vehicles. | | | | | | | | | |
| Squat | | | | | | | | | | | | | | |
| Crawl | | | | | | | | | | | | | | |
| Climb | | | | | | | | | | | | | | |
| Run | | | | | | | | | | | | | | |
| Reach above shoulder level | | | | | | | | | | | | | | |
| Operate a motor vehicle | | | | | | | | | | | | | | |
| | | | | | <table border="1"> <thead> <tr> <th>Right Extremity</th> <th>Left Extremity</th> <th>Simultaneous</th> </tr> </thead> <tbody> <tr> <td>Yes No</td> <td>Yes No</td> <td>Yes No</td> </tr> </tbody> </table> | Right Extremity | Left Extremity | Simultaneous | Yes No | Yes No | Yes No | | | |
| Right Extremity | Left Extremity | Simultaneous | | | | | | | | | | | | |
| Yes No | Yes No | Yes No | | | | | | | | | | | | |

4. Work Environment Restrictions

Can this employee:

- Be exposed to marked changes in temperature and humidity? Yes No
- Be exposed to unprotected heights? Yes No
- Be around moving machinery? Yes No

5. Other Restrictions

- Can this employee restrain combative clients? Yes No
- Does this employee have any visual or hearing impairment requiring accommodation? Yes No

If "Yes", please explain: _____

6. Based on your examination(s) of this employee, are there any known problems of a general nature, including any medications prescribed for the diagnosis listed, that would interfere with this employee returning to work?

Yes No If "Yes", please explain: _____

7. When, in your estimation, will this employee be ready to return to full duty? Date _____

Comments: _____

Physician's Signature _____

Telephone Number _____

Date _____

ALTERNATE DUTY PROGRAM

New York State and several public employee unions have negotiated Alternate Duty Programs as part of the employer-provided benefits associated with workers' compensation disabilities.

These programs allow employees in the affected bargaining units, who have been disabled temporarily due to occupational accidents, to return to work prior to full recovery and work in assignments that meet both the needs of the agency and the medical limitations of the employees.

Employees benefit from these programs by returning to work and becoming productive more quickly, thus enhancing the recuperation process. Agencies benefit from these programs because they have the services of employees who would otherwise be unable to return to work.

When an employee's level of disability is classified at 50 percent or less (mildly or moderately disabled) and the employee is within 60 days of full recovery, he/she is qualified for an alternatedutyassignment. Theagencywilluse theinformationprovidedonthisform todesign an assignment that is consistent with the employee's limitations and capabilities. An assignment will be given to an employee initially for no more than 60 days. Agencies can extend assignments on a discretionary basis until the employee has fully recovered and returns to his/her regular assignment.

During the period of alternate duty, the employee will be expected to provide periodic medical documentation from the attending physician to verify that the employee's medical condition and the assignment remain consistent and to confirm full recovery prior to returning to the regular job assignment.

Questions concerning the information on this form should be directed to the evaluating physician at the telephone number listed. Questions concerning the alternate duty assignment should be directed to the employee's agency.