Educational Service District 105
33 So. 2nd Ave.
Yakima, WA 98902

DOCTOR'S ESTIMATE OF PHYSICAL CAPACITIES

Name of Claimant: ____________________ **Claim #:** __________

Important: Please complete the following items based on your clinical evaluation of the claimant and other testing results. Any item that you do not believe you can answer should be marked N/A. Percentages refer to a workday.

I. In an 8 hour workday, worker can: (Circle full capacity for each activity)

	Total at one time (hours)											Total during entire 8 hour day (hours)									
A) Sit	0	1/2	1	2	3	4	5	6	7	8	A) Sit	0	1/2	1	2	3	4	5	6	7	8
B) Stand	0	1/2	1	2	3	4	5	6	7	8	B) Stand	0	1/2	1	2	3	4	5	6	7	8
C) Walk	0	1/2	1	2	3	4	5	6	7	8	C) Walk	0	1/2	1	2	3	4	5	6	7	8

II. Worker can lift: *(Address any restrictions in lifting from the floor or to overhead in "Remarks" section)*

III. Worker can carry:

	Never		Seldom (0-1%)		Occasionally (2-33%)		Frequently (34-66%)		Continuously (67-100%)	
	Lift	Carry	Lift	Carry	Lift	Carry	Lift	Carry	Lift	Carry
A) Up to 5 lbs										
B) 6-10 lbs										
C) 11-20 lbs										
D) 21-25 lbs										
E) 26-50 lbs										
F) 51-100 lbs										

IV. Worker can use hands for repetitive tasks such as:

	Simple grasping		Pushing & pulling		Fine manipulating	
A) Right	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
B) Left	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

V. Worker can use feet for repetitive movements as in operating foot controls:

Right ☐ Yes ☐ No Left ☐ Yes ☐ No

VI. Worker is able to:

	Not at all	Seldom (0-1%)	Occasionally (2-33%)	Frequently (34-66%)	Continuously (67-100%)
A) Bend					
B) Squat					
C) Kneel					
D) Crawl					
E) Climb					
F) Reach above shoulder level					

VII. Restriction on activities involving:

	Yes	No	If "Yes", explain:
A) Unprotected heights			
B) Being around moving machinery			
C) Exposure to marked changes in temp & humidity			
D) Driving automotive equipment			

E) Exposure to dust, fumes and gasses (Restrictions): ______________________________

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Remarks (on above, on other functional limitations):

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If a performance-based physical capabilities evaluation is requested, may the worker be tested to tolerance? If not, what are the restrictions?

☐ Yes ☐ No ______________________________

Date: __________ Signature of Physician: ____________________