JEFFERSON SCHOOL DISTRICT - ESTIMATED FUNCTIONAL CAPACITIES FORM

To be completed prior to the employee's return to work.

Health Care Provider: Please complete the following items based on your estimated clinical evaluation of ____________________________ (Employee's Name). Any item that you do not believe you can answer can be marked N/A. **(Any additional comments can be provided on a separate sheet.)**

1. My area of medical practice is: ____.

2. The patient's condition had manifested itself in the following manner (specifically describe including impact on ability to work, attend school or perform activities of daily living):

   ____

   ____

3. Describe other relevant medical facts, including symptoms, diagnosis, or any regimen of continuing treatment.

   ____

   ____

4. In an 8 hour workday, the patient can: (Circle full capacity for each activity)

									Continuously	With Rests
Sit	1	2	3	4	5	6	7	8 (hrs)	_______	_________
Stand	1	2	3	4	5	6	7	8 (hrs)	_______	_________
Walk	1	2	3	4	5	6	7	8 (hrs)	_______	_________

	NEVER	OCCASIONALLY (0% TO 33%)	FREQUENTLY (34% TO 66%)	CONTINUOUSLY (67% TO 100%)
Lift/Carry:				
10 lbs.	_______	________	________	________
11-20 lbs.	_______	________	________	________
21-50 lbs.	_______	________	________	________
51-100 lbs.	_______	________	________	________
Push/Pull:				
10 lbs.	_______	________	________	________
11-20 lbs.	_______	________	________	________
21-50 lbs.	_______	________	________	________
51-100 lbs.	_______	________	________	________
Bend:	_______	________	________	________
Squat:	_______	________	________	________
Crawl:	_______	________	________	________
Climb:	_______	________	________	________
Reach above shoulder level:	_______	________	________	________

5. Cognitive Job Duties: For each item listed below, using a scale of 1 to 5 (1 being the least complex; 5 the highest), circle the complexity level that you feel the patient can perform with his/her medication:

Comprehend and follow instructions	1	2	3	4	5
Perform assigned tasks	1	2	3	4	5
Perform complex or varied tasks under time constraints (i.e., meet deadlines)	1	2	3	4	5
Make decisions	1	2	3	4	5
Relate to others (co-workers)	1	2	3	4	5
Relate to other (public)	1	2	3	4	5
Ability to communicate orally or written effectively	1	2	3	4	5

6. Patient can use hands for repetitive actions such as:

	Simple Grasping	Pushing & Pulling	Fine Manipulating
Right	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Left	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

Patient can use feet for repetitive movements as in operating foot controls:

Right	Left	Both
☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no

7. Current ability to work:

Can patient now work? ____________________
Part-time: (hrs/day) ____________________
Full-time: (yes) ____________________
Overtime limitation: ☐ yes ☐ no
Please explain: ____________________
____
Disability Rating: __________ %

8. Please describe in detail all limitations on work for the employee and the expected duration of such restrictions:

____

____

Dated this ______________ day of ____________, 20___.

______________________________ ______________________
Signature of Health Care Provider/ Telephone Number
Christian Science Practitioner

______________________________ ______________________
Address City/State

5/24/10