



EMPLOYEE:	1. PLEASE HAVE EACH HEALTHCARE CLINICIAN COMPLETE THIS FORM AT EACH VISIT TO THE CLINICIAN 2. PLEASE PROVIDE A COPY OF THE COMPLETED FORM TO YOUR SUPERVISOR AFTER EACH VISIT
CLINICIAN:	PLEASE COMPLETE, SIGN AND FAX THIS FORM TO EMPLOYMENT SERVICES AT 651-696-6612

EMPLOYEE INFORMATION:

Today's Date: _____ Report Completed by: _____

Employee Name (First, Last, Middle Initial): _____

Date of Birth: _____

Date of Incident/Injury: _____ Time of Incident/Injury: _____

Work Related Not Work Related Undetermined

Permanent Disability: Likely Not Likely Undetermined

MN/MMI: NO YES If yes, give date: _____

CLINICAL FINDINGS:

Describe: _____

Diagnosis: _____

Treatment: _____

RETURN TO WORK:

Return to work with no limitations on _____ / _____ / _____

Return to work with limitations on _____ / _____ / _____ through _____ / _____ / _____

Unable to work from _____ / _____ / _____ through _____ / _____ / _____

EMPLOYEE'S CAPABILITIES:

	Not at all	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%		Not at all	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%
Lift/Carry					Bend				
0-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____degrees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist/Turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kneel/Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull					Stand/Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Over Shoulder Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ladder/ Stair Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-75 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of LEFT Hand for grasping, typing, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76-100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of RIGHT Hand for grasping, typing, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

AVOID the following activities:

Capabilities Apply To: Work Home Leisure

Comments: _____

Return to Clinic on: _____ Date: _____ Time: _____

Clinician Name (please print): _____ Clinic Name: _____

Clinician Signature: _____ Clinic Address: _____

Clinician Phone: _____ Clinic Fax: _____