**DEPARTMENT OF ADMINISTRATIVE SERVICES**
**WORK CAPACITY FORM**

Name: ___________________________________________ Date of Birth: __________________

Job Title: _________________________________________ Claim No.: ______________________

Dear Doctor:

Many State of Ohio agencies have early return to work programs or are willing to make temporary work assignment adjustments to enable a State of Ohio employee to return to work while they complete their recovery. Please help us in our efforts to return our employees to work by completing the following questionnaire and returning to us by fax at (614) 466-0831. Thank you for your assistance.

1. What job duties is patient unable to perform?

2. In an 8-hour workday, person can: (Circle full capacity for each activity)

   ![Table of activities](https://via.placeholder.com/150)

3. Person can lift and carry: Never Occasionally Frequently Constantly

   ![Lifting capacities](https://via.placeholder.com/150)

4. Person can push/pull: Never Occasionally Frequently Constantly

   ![Pushing and pulling capacities](https://via.placeholder.com/150)

5. Person can do repetitive movements as in keyboard operation:

<table>
<thead>
<tr>
<th>Right Hand/Arm</th>
<th>Right Foot/Leg</th>
<th>Left Hand/Arm</th>
<th>Left Foot/Leg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

6. Person can:

   ![Movement capacities](https://via.placeholder.com/150)

   (over)
7. Any difficulties involving: None Mild Moderate Severe
   Talking
   Hearing
   Tasting/Smelling/Vision
8. Any restrictions of activities involving:
   None Mild Moderate Severe
   Exposure to cold/heat
   Noise
   Exposure to Fumes
   Driving
9. Is this person involved with treatment and/or medication that might affect his/her ability to work:
   [ ] No  [ ] Yes, Describe: __________________________________________________________
   ____________________________________________________________________________
10. Patient’s condition prevents them from working:
    Temporarily _____  For longer than 12 months _____  Permanently _____
11. If disability is temporary, patient’s estimated date of release to return to work:
    With restrictions listed above Mo. _____  Day _____  Yr. _____
    For regular occupation without restrictions Mo. _____  Day _____  Yr. _____
    On a part-time basis Mo. _____  Day _____  Yr. _____
    Hours per day _____  days per week _____  # of weeks _____
    Additional Comments: _________________________________________________________________________
    _______________________________________________________________________________________
    _______________________________________________________________________________________
    _______________________________________________________________________________________
    _______________________________________________________________________________________
    Name(treatment provider) Please print  Specialty  Fed ID#
    Street address, City, State and Zip
    Telephone (area code)  Fax (area code)  E-mail address