

Human Resources Division Benefits Administration Services 30 East Broad Street, 28th Floor Columbus, Ohio 43215

## DEPARTMENT OF ADMINISTRATIVE SERVICES WORK CAPACITY FORM

Name:		····	Date of Birth:		
Job Title:			Claim No.:	<del> </del>	
Dear Doctor:					
Many State of Ohio agencies I adjustments to enable a State our efforts to return our emplo (614) 466-0831. Thank you for	of Ohio employee eyees to work by	e to return to work while completing the follow	they complete the	ir recovery. Please help us in	
What job duties is patient ur	able to perform?				
2. In an 8-hour workday, perso	n can: (Circle	full capacity for each ac	ctivity)		
TOTAL (hours)					
Sit 0 1 2 3 Stand 0 1 2 3 Walk 0 1 2 3	4 5 6 4 5 6 4 5 6	7 8 7 8 7 8			
3. Person can lift and carry:	Never			Constantly	
Up to 10 lbs. 11-20 lbs. 21-50 lbs. Over 50 lbs.		( 1% - 33% )	( 34%- 66% )	( 67%-100 ) 	
4. Person can push/pull:	Never			Constantly ( 67%-100 )	
Up to 10 lbs. 11-20 lbs. 21-50 lbs. 51-100 lbs. Over 100 lbs.				( 07 70-100 ) 	
5. Person can do repetitive movements as i Right Hand/Arm Right Foot/L			n Left Foo	nt/Leg	
Yes No	Yes I	No Yes	No Yes	No	
6. Person can:	Person can: Never			Constantly (67%-100)	
Climb Balance Stoop Kneel Crawl Reach/Handle		(over)			

7.	Any difficulties involving:	None	Mild	Moderate	Severe					
	Talking									
	Hearing Tasting/Smelling/Vision	<del></del>		<del></del>						
	-	<del></del>		<del></del>	<del></del>					
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	<del></del>				
	For regular occupation withou	ut restrictions		Mo Day	/ Yr	<del></del>				
	On a part-time basis			Mo Day	/ Yr	<del></del>				
Hours per day days per week # of weeks										
Additional Comments:										
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Name(treatment provider) Please print			Specialty	Fed ID#						
Street address, City, State and Zip										
Tel	ephone (area code)	Fax (area code)		E-mail address						