ATTACHMENT B1
ESTIMATED FUNCTIONAL CAPACITIES FORM

RE: _____
D/I: _____
WC#: _____
Physician: _____
Date: _____

NOTE: THE EMPLOYER HAS LIGHT DUTY AVAILABLE.

1. Can patient return to any work according to the restrictions defined below?

YES _____, specify release-to-work date_____
Full-time_____ Part-time_____ Hours per week_____

NO _____, give estimated date for release to light duty work_____

Give estimated date for release to regular work. Regular work MAY mean no restrictions. _____

NOTE: If there are no physical limitations, proceed to item #4.

2. Please indicate physical limitations on a 8-hour-a-day basis:

Percent of Day:	**Never (0%)**	**Occasional (1-33%)**	**Frequent (34-66%)**	**Unrestricted (67-100%)**
PUSHING:	_____	_____	_____	_____
PULLING:	_____	_____	_____	_____
LIFTING:				
Sedentary 1-10	_____	_____	_____	_____
Light 11-25	_____	_____	_____	_____
Medium 26-50	_____	_____	_____	_____
Heavy 51-100 pounds	_____	_____	_____	_____
CARRYING: 1-10	_____	_____	_____	_____
11-25	_____	_____	_____	_____
26-50	_____	_____	_____	_____
51-100 pounds	_____	_____	_____	_____
SITTING:	_____	_____	_____	_____
STANDING:	_____	_____	_____	_____
WALKING:	_____	_____	_____	_____
RUNNING:	_____	_____	_____	_____
STAIR CLIMBING	_____	_____	_____	_____
BENDING:	_____	_____	_____	_____
Percent of Day:	**Never**	**Occasional**	**Frequent**	**Unrestricted**

	(0%)	(1-33%)	(34-66%)	(67-100%)
CRAWLING:	_____	_____	_____	_____
SQUATTING:	_____	_____	_____	_____
KNEELING:	_____	_____	_____	_____
STOOPING:	_____	_____	_____	_____
CROUCHING:	_____	_____	_____	_____
LADDER CLIMBING:	_____	_____	_____	_____
FORWARD REACHING:	_____	_____	_____	_____
TWISTING:	_____	_____	_____	_____
SIDE BENDING:	_____	_____	_____	_____
OVERHEAD REACH:	_____	_____	_____	_____
GRASPING:	_____	_____	_____	_____
HANDLING:	_____	_____	_____	_____
FINGERING:	_____	_____	_____	_____

Are the above restrictions permanent? Yes_____ No_____

3. Patient can use feet for repetitive movement as in operating foot controls:

Right Foot	Left Foot	Both Feet
Yes___ No___	Yes___ No___	Yes___ No___

4. Please specify any additional recommendations/comments you may wish to make regarding this patient's return to full-time or part-time employment:

_____
_____
_____
_____
_____
_____

_____ _____
Physician's Signature Date

efc1: Please return to 235 S.Beretania St.13Fl,Honolulu, HI 96813 or facsimile 587-0888