

**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	Occasional	Frequent	Unrestricted
		(0%)	(1-33%)	(34-66%)	(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:
- | <u>Right Foot</u> |        | <u>Left Foot</u> |        | <u>Both Feet</u> |        |
|-------------------|--------|------------------|--------|------------------|--------|
| 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:

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\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

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