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
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<th>Activity</th>
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<th>(34-66%)</th>
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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

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