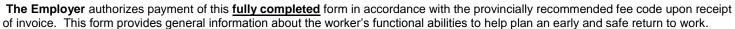
## **Functional Abilities Form for Return-to-Work**



NAGEMENT INSTITUTE INC.

WORKER (PATIENT) INFORMATION: To be completed by Worker	
I authorize the release of the information below to my employer & Disability Management Institute (DMI).	
Worker Name: Worker Sigr	nature: Date:
Current Position:	A Job Description or Position Summary is attached
CURRENT MEDICAL INFORMATION: To be completed by Physician	
Date of Exam (dd/mm/yy): Date of Next Appointment:	
Patient is FIT for REGULAR DUTIES and FULL WORK SHIFT.	
Patient is FIT for GRADUATED WORK SCHEDULE: hrs/day for week(s)	
Patient is FIT for MODIFIED / ALTERNATE DUTIES (please complete limitations section below).	
□ Patient is not expected to return to work.	
Complete Recovery Expected: Yes D No Anticipated date, return to full duties	
OPERATING MOVING EQUIPMENT / DRIVING (select one)         CAN operate moving equipment / drive         Is your patient capable of performing the duties of a Safety Sensitive Position?         Yes         No         Is your patient taking any medication that would affect their ability to perform their job duties safely?         Yes         No limitations	
<ul> <li>Limited uneven ground (loose rock, steep slopes, heavy/deep</li> <li>No prolonged periods &gt; 30 minutes</li> <li>Not more than 100 meters</li> <li>Unable to walk without assistance (cane, crutches)</li> </ul>	
<ul> <li>POSTURES (select all that apply)</li> <li>No limitations</li> <li>Must be able to change from sitting to standing at own discret</li> <li>No sitting duration &gt; 30 minutes</li> <li>No standing duration &gt; 30 minutes</li> </ul>	ion CLIMBING AND BALANCE (select all that apply) No limitations Stairs only No vertical ladders No working at heights (over 6 feet)
UPPER LIMB (select all that apply) No limitations	ESTIMATED DURATION OF RESTRICTIONS/MODIFIED DUTIES: week(s)/days(s)
<ul> <li>No above shoulder reaching: Left Right</li> <li>No firm gripping or twisting: Left Right</li> <li>No writing or keyboard use: Left Right</li> </ul>	Over 3 months Comments:
Medical Provider's Signature	Date:
Medical Provider's Name (print)	Phone: