

5. Person can:	Never	Occasionally (1% - 33%)	Frequently (34%- 66%)	Constantly (67%-100)
Climb	_____	_____	_____	_____
Balance	_____	_____	_____	_____
Stoop	_____	_____	_____	_____
Kneel	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Reach/Handle	_____	_____	_____	_____

6. Any difficulties involving:	None	Mild	Moderate	Severe
Talking	_____	_____	_____	_____
Hearing	_____	_____	_____	_____
Tasting/Smelling/Vision	_____	_____	_____	_____

7. Any restrictions of activities involving:	None	Mild	Moderate	Severe
Exposure to cold/heat	_____	_____	_____	_____
Noise	_____	_____	_____	_____
Exposure to Fumes	_____	_____	_____	_____
Driving	_____	_____	_____	_____

8. Is **this** person involved with treatment and/or medication that might affect his/her ability to work:

No Yes, Describe: _____

9. Can this person return to work according to restrictions defined above?

Yes No, estimated date for return to work: _____

Work full-time? Yes No OR Work part-time? _____ Hrs./Day

10. When **can** person return to work **WITHOUT** restrictions? _____

11. Additional Comments: _____

 Physician's Signature

 Date