



IME DOCTOR'S ESTIMATE OF PHYSICAL CAPACITIES

Name of Claimant

Claim Number

Important: Please complete the following items based on your clinical evaluation of the claimant and other testing results. Any item that you do not believe you can answer should be marked N/A. Percentages refer to a workday.

I. In an 8 hour workday, worker can: (Circle full capacity for each activity)

Total at one time (hours)										Total during entire 8 hour day (hours)											
A) Sit	0	1/2	1	2	3	4	5	6	7	8	A) Sit	0	1/2	1	2	3	4	5	6	7	8
B) Stand	0	1/2	1	2	3	4	5	6	7	8	B) Stand	0	1/2	1	2	3	4	5	6	7	8
C) Walk	0	1/2	1	2	3	4	5	6	7	8	C) Walk	0	1/2	1	2	3	4	5	6	7	8

II. Worker can lift: *(Address any restrictions in lifting from the floor or to overhead in "Remarks" section)*

III. Worker can carry:

	Not at all		Seldom (1 - 10%)		Occasionally (11 - 33%)		Frequently (34 - 66%)		Continuously (67 - 100%)	
	Lift	Carry	Lift	Carry	Lift	Carry	Lift	Carry	Lift	Carry
A) Up to 5 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) 6 - 10 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) 11 - 20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) 21 - 25 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) 26 - 50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) 51 - 100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. Worker can use hands for repetitive tasks such as:

	Simple grasping		Pushing & pulling		Fine manipulating	
A) Right	<input type="checkbox"/>	Yes <input type="checkbox"/> No	<input type="checkbox"/>	Yes <input type="checkbox"/> No	<input type="checkbox"/>	Yes <input type="checkbox"/> No
B) Left	<input type="checkbox"/>	Yes <input type="checkbox"/> No	<input type="checkbox"/>	Yes <input type="checkbox"/> No	<input type="checkbox"/>	Yes <input type="checkbox"/> No

V. Worker can use feet for repetitive movements as in operating foot controls:

Right Yes No Left Yes No

VI. Worker is able to:

	Not at all	Seldom (1-10%)	Occasionally (11 - 33%)	Frequently (34 - 66%)	Continuously (67 - 100%)
A) Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VII. Restriction on activities involving:

- A) Unprotected heights
- B) Being around moving machinery
- C) Exposure to marked changes in temp & humidity
- D) Driving automotive equipment

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

If "Yes," explain:

E) Exposure to dust, fumes and gasses (Restrictions): _____

Remarks (on above, on other functional limitations):

If a performance-based physical capabilities evaluation is requested, may the worker be tested to tolerance? If not, what are the restrictions?

Yes No

Date

Signature of Physician