

Employee Services
 155 Cottage St NE:U130
 Salem, OR 97301
 503-378-3622

Physical Assessment Form

To assist in a fast recovery the Department of Administrative Services strives to return injured employees to work as soon as possible after the date of injury. In order to do this safely we will need the following information.

Employee Name: _____ Date of Injury: ____/____/____

Please Print

Date of Visit: ____/____/____ Date of next Visit: ____/____/____ Claim Number: _____

Return to Work Status

May return to work with no restrictions: (date) ____/____/____ May return to Modified work: (date) ____/____/____

Estimated Duration of Modified Work: _____ (list restrictions below)

The commute to this job is within the physical limits of the worker: ___yes___ no

Physical Limitations: (No Comment Will Mean No Limits)

Definitions of limits: No limits = no restrictions Minimal = 1% to 5% of job
 Frequently = 66% of job Not ok = none
 Occasionally = 33 % of job

Capabilities						Lifting					
	No Limits	Frequently ok	Occasionally ok	Minimal ok	Not ok		No Limits	Frequently ok	Occasionally ok	Minimal ok	Not ok
Bend						0 to 10 lbs.					
Squat						11 to 20 lbs.					
Crawl						21 to 35 lbs.					
Twist						36 to 50 lbs.					
Reach over shoulders						51 to 75 lbs.					
Walk ramps. Max incline: _____						Carry: Max ok: _____					
Use stairs/steps/step-stools						Use arms/repeated pushing / pulling					
Use ladders						Use arms/repeated grasp/lift/carry					
Walk on rough/uneven surfaces						Use hands/repeated fine manipulations					
Kneeling						Other					

Medication:

Please list any medication prescribed for use during working hours that would affect alertness or ability to respond in an emergency.

Endurance:

Our work shifts vary from 8 hrs to 16 hrs a day. Please indicate the number of continuous hours the Employee may engage in each activity.

Total hours per. Day = _____
Continual hours sitting = _____
Continual hours standing = _____
Continual hour walking = _____

Diagnosis: _____

Prognosis (comments): _____

Medically stationary: Y / N date: ____/____/____

Are these restrictions permanent: Y / N

Health Care Provider Signature: _____ Date: ____/____/____

Address: _____ Phone: _____ - _____ - _____

Please have completed at each visit and return to your Supervisor.
**** Original document to Employee Services Office****