HENRICO COUNTY GOVERNMENT AND PUBLIC SCHOOLS

PHYSICAL CAPABILITIES FORM

Please see instructions on reverse side of this form.

PART I. EMPLOYEE INFORMATION		
Employee Name:	Injury Date:	Today's Date:
Department or School:	Name of Supervisor:	Supervisor's Phone Number:

PART II. TO BE COMPLETED BY PHYSICIAN ONLY
Complaint(s)/Diagnosis: (Include Part of Body Involved - Left/Right, Upper/Lower)
Patient May Return to Work: _____ Regular _____ Restricted (Date: _____)
PATIENT RESTRICTIONS
A. Length of Restriction: (Number of Days)_____ B. Work Restrictions: (Check all that apply)
Standing Restrictions: _____ Lifting Restrictions: _____ Bending/stooping restrictions: _____
Pushing/Pulling Restrictions: _____ Sitting Restrictions: _____ Other Restrictions: _____
C. Medication Prescribed:
D. Does medication prevent patient from working on or around moving equipment, machinery, driving? Yes _____ No _____ If the answer to question D is yes, explain:
E. Date of Follow-up Appointment:

REFERRAL (If patient is referred to another physician, complete the next line:)	
Date of Appointment:	Physician's Name:

TREATMENT FACILITY		
Name of Treatment Facility:	Address of Treatment Facility:	
Printed Name of Physician:	Signature of Physician:	Date:

Submit bills : Henrico County Risk Management **Department, P. O. Box 90775**
Henrico, VA 23273-0775 (804) 501-5661 FAX: (804) 501-5663

<u>PHYSICIAN:</u> Modified duty may be provided to this employee. Please provide work restriction information and duration.

INSTRUCTIONS FOR THE PHYSICIANS OFFICE

1. Please fax or deliver this form to The Risk Management office at (804) 501-5663
2. Please provide a copy of this form to the employee.
3. Obtain health insurance information should this claim be denied under workers' compensation.

EMPLOYEE: **Please deliver this form completed by the doctor to your supervisor.**