County of Henrico
Department of Finance, Risk Management Division

PHYSICAL CAPABILITIES FORM

FOR ALL NON-WORKERS' COMPENSATION RELATED INJURIES & ILLNESSES

Instructions for the Employee:
Please provide this form to your physician to be completed and signed. You must submit this completed and signed form to your supervisor. ***Please include this form with requests for Light Duty.***

Instructions for the Physician's Office:
Please obtain health insurance information from patient should this claim be denied under workers' compensation. Please provide a copy of this completed and signed form to patient.

EMPLOYEE INFORMATION *(To be Completed by the Employee)*

Name of Employee: _____ _____ _____ **Date of Injury or Illness:** _____
Last *First* *MI*

Department: _____ **Division / School:** _____

Supervisor's Name: _____ **Supervisor's Work Phone:** _____

NATURE OF INJURY OR ILLNESS *(To be Completed by the Physician Only)*

Nature of Injury or Illness: _____

Work Status: ☐ **Regular Duty** ☐ **Light Duty** ☐ **Out of Work**

(Return Date: _____) *(Return Date: _____)* *(From: _____ to _____)*

PATIENT RESTRICTIONS *(To be Completed by the Physician Only)*

Length of Restriction: _____

Type of Restriction:

☐ **Standing** (Duration: _____ HRS) ☐ **Walking/Moving** (Duration: _____ HRS)

☐ **Sitting** (Duration: _____ HRS) ☐ **Pushing/Pulling** (Weight: _____ LBS)

☐ **Lifting** (Weight: _____ LBS) ☐ **Bending/Stooping**

Other: _____

Medication Prescribed: _____

Does the medication prevent patient from performing their essential job duties/functions working on or around moving equipment, machinery, or driving? ☐ Yes ☐ No

If yes, explain: _____ **Date of Follow-up visit:** _____

REFERRAL *(To be Completed by the Physician Only)*

Physician's Name: _____ **Date of appointment:** _____

SIGNATURE *(To be Completed by the Physician Only)*

_____ _____ _____
Physician's Signature **Printed Name** **Date**

Name of Treatment Facility: _____

Address of Treatment Facility: _____