



County of Henrico
 Department of Finance, Risk Management Division
PHYSICAL CAPABILITIES FORM

FOR WORKERS' COMPENSATION | CLAIM NO: _____

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 to the patient and email, fax, or mail this form to PMA.

EMPLOYEE INFORMATION (To be Completed by the Employee)

Name of Employee: _____ Date of Injury: _____
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 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: _____

PLEASE SUBMIT THIS DOCUMENT AND RELATED BILLS TO PMA BY MAIL, FAX, OR EMAIL

Mail:
 PMA Customer Service Center
 PO Box 5231
 Janesville, WI 53547-5231

Fax:
 800-432-9762

Email:
ClaimsMail@pmagroup.com
 (Include the Employee's Name & Date of Injury in the Subject Line)