**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. 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 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:** _____