NDSCS
Report of Workability

PART 1-Employee Complete	
Employee Name:	SSN:
Attending Physician's Name & Phone #:	Current Position:

I hereby authorize my medical providers to release all medical information in regard to this condition to my employer, or their representative, with the understanding that this information shall remain confidential.

Employee Signature_____ Date_____

PART 2 - All Areas To Be Completed By Attending Physician.

Date of examination/treatment:___/___/____

Employee may return to work: ___/___/___ without restrictions with the following restrictions

1. In an 8 hour work day employee may

	1-4 hours	4-6 hours	6-8 hours		1-4 hours	4-6 hours	6-8 hours
Stand/Walk				**Squat**			
Drive				**Kneel**			
Sit				**Reach Above Shoulder**			
Bend				**Climb**			
Twist				**Stoop**			
Crouch				**Balance**			
Push/Pull				**Lift Up to _____lbs**			

Worker may use hand(s) for repetitive: _____Single Grasping _____Pushing/Pulling _____Fine Manipulation

Worker may use foot/feet for repetitive movement such as in operating foot controls:

Left: ____Yes ____No Right: ____Yes ____No

Worker can use head/neck in:

Static Position ___Yes ___No Frequent Flexing ___Yes ___No Frequent Rotating ___Yes ___No

Other instructions and/or limitations:

The above restrictions are in effect until: ____/____/____ or until the patient is reevaluated on ____/____/____

By my signature below, I declare that the statements made on this form are true and accurate.

_____

Physician's Signature Date

(This completed form must be filed with the NDSCS Human Resources Office)