WORK RELATED ACTIVITIES (PHYSICAL)

Name of Claimant: SSN:

IMPORTANT: PLEASE COMPLETE THE FOLLOWING ITEMS BASED ON YOUR CLINICAL EVALUATION OF THE CLAIMANT AND OTHER TESTING RESULTS. ANY ITEM YOU DO NOT BELIEVE YOU CAN ANSWER SHOULD BE MARKED N/A (NOT ANSWERABLE).

Note: In terms of an 8-hour workday, "occasionally" equals 1% to 33%; "frequently," 34% to 66%; "continuously," 67% to 100%

I. In an 8-hour workday, Claimant can: (Circle full capacity in hours for each activity)

TOTAL AT ONE TIME										
A) Sit	0	½	1	2	3	4	5	6	7	8
B) Stand	0	½	1	2	3	4	5	6	7	8
C) Walk	0	½	1	2	3	4	5	6	7	8
TOTAL DURING ENTIRE 8-HOUR DAY										
A) Sit	0	½	1	2	3	4	5	6	7	8
B) Stand	0	½	1	2	3	4	5	6	7	8
C) Walk	0	½	1	2	3	4	5	6	7	8

II. Claimant can lift:

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A) Up to 5 lbs.	☐	☐	☐	☐
B) 6 to 10 lbs.	☐	☐	☐	☐
C) 11 to 20 lbs.	☐	☐	☐	☐
D) 21-25 lbs.	☐	☐	☐	☐
E) 26 to 50 lbs.	☐	☐	☐	☐
F) 51 to 100 lbs.	☐	☐	☐	☐

III. Claimant can carry:

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A) Up to 5 lbs.	☐	☐	☐	☐
B) 6 to 10 lbs.	☐	☐	☐	☐
C) 11 to 20 lbs	☐	☐	☐	☐
D) 21 to 25 lbs.	☐	☐	☐	☐
E) 26 to 50 lbs.	☐	☐	☐	☐
F) 51 to 100 lbs.	☐	☐	☐	☐

IV. Claimant can use hands for repetitive action such as:

	SIMPLE GRASPING	PUSHING & PULLING OF ARM CONTROLS	FINE MANIPULATION
A) Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
B) Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

V. Claimant can use feet for repetitive movements as in pushing & pulling of leg controls:

RIGHT	LEFT	BOTH
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

VI. Claimant is able to:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A) Bend	☐	☐	☐	☐
B) Squat	☐	☐	☐	☐
C) Crawl	☐	☐	☐	☐
D) Climb	☐	☐	☐	☐
E) Reach	☐	☐	☐	☐

VII. Restriction of activities involving:

	NONE	MILD	MODERATE	TOTAL
A) Unprotected heights	☐	☐	☐	☐
B) Being around moving machinery	☐	☐	☐	☐
C) Exposure to marked changes in temperature & humidity	☐	☐	☐	☐
D) Driving automotive equipment	☐	☐	☐	☐
E) Exposure to dust, fumes & gases	☐	☐	☐	☐

VIII. Does Claimant have a need to lay down during the workday? ☐ Yes ☐ No
If yes, how often?

IV. Does Claimant need to elevate his/her leg during the workday? ☐ Yes ☐ No
If yes, how often?

Signature of Physician **Address** **Date**